Universal Referral Form

Date of Referral: ________________

Client Name:______________________________________ Client Date Of Birth: __________________

Client is aware of Referral: YES NO Client motivated for recovery: YES NO UNSURE

Phone Number: ______________________ Alternate Phone Number: _________________________

Mailing Address: ____e-mail: ____________________

Physical Address:____

Does client have reliable transportation during daytime hours? YES NO

Does Client have Health Insurance? YES NO

Name of Insurance Company? (Medicaid **IS** health insurance)_____________________________________

Insurance Number: ____

CLIENTS CANNOT BE SEEN WITHOUT INSURANCE INFORMATION
OR ABILITY TO PAY DETERMINED **PRIOR TO FIRST VISIT**!

Suspected or confirmed addiction: (heroin, prescription medication, meth, poly-substance, alcohol, other).
____

Other physical health or mental health diagnosis suspected or confirmed:_____________________________
____

Is this referral to fulfill legal system requirements? YES NO
If YES: please explain: (parole, probation, etc.)____

Referring Professional: ____________________________ Phone: _______________________

Organization: ___________________________________ Email: _______________________
Fax: _________________________

Next Steps:
-Please **fax** (along with a signed release of information) to **(719)-966-8108**
-Call (970)-824-LIFE to confirm receipt of this referral.
-We will attempt to follow up with the client/patient and you within 3 business days.