RISE PROGRAM

'RECOVERY IS EMPOWERING'

REFERRAL FORM

PLEASE PRINT ALL INFORMATION LEGIBLY

DATE: _____ REFERRING AGENCY: _____

NAME OF PERSON MAKING REFERRAL: _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

TELEPHONE: _____ EXT: _____ FAX: _____

EMAIL ADDRESS: _____

REFERRED FROM:

____ ALCOHOL OR OTHER DRUG PROGRAM

____ FAMILY MEMBER /SELF

____ PAROLE OFFICER

____ ATTORNEY (PUBLIC OR PRIVATE)

____ HOSPITAL/MEDICAL PROFESSIONAL

____ DCF

____ PROBATION/COURT SUPPORT SERVICE DIVISION INCLUDING FAMILY & BAIL SERVICES

____ SOCIAL WORKER

DEMOGRAPHICS:

PARTICIPANT FIRST NAME: _____ M: _____ LAST NAME: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____
MONTH/DAY/YEAR

ADDRESS: _____
STREET CITY STATE ZIP CODE

TELEPHONE: (HOME)_____ CELL _____

TYPE OF INSURANCE: **INSURANCE PROVIDER:**
PRIMARY HUSKY MEDICAID (TITLE19)

POLICY #: _____ GROUP #: _____ EFFECTIVE DATE _____

DOES PARTICIPANT HAVE A LEGAL HISTORY: ____ YES ____ NO

IF YES TO ANY OF THE ABOVE, PLEASE LIST ALL CHARGES AND STATUS: _____

_____

_____

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CLINICAL INFORMATION

PLEASE PRINT ALL INFORMATION LEGIBLY

MEDICAL/MENTAL HEALTH (ALL PARTICIPANTS MUST BE MEDICALLY CLEARED PRIOR TO ADMISSION WITH DOCUMENTATION):

DOES PARTICIPANT HAVE A PHYSICIAN: ___ YES ___ NO PSYCHIATRIST: ___ YES ___ NO DENTIST: ___ YES ___ NO

IS PARTICIPANT CURRENTLY TAKING ANY MEDICATIONS: ____ YES ___ NO

LIST OF MEDICATION AND DOSAGE: _____

_____

SUBSTANCE USE CLINICAL DIAGNOSIS: _____

_____

_____

_____

DSM 5 DIAGNOSIS: _____

_____

_____

_____

_____

EDUCATION:

LAST SCHOOL ATTENDED: _____TOWN:_____

GRADE: _____ DATE OF ENTRY: _____ SPECIAL SERVICES: ____ YES ____ NO

IF YES, PLEASE INDICATE _____

_____

_____

_____