madrona recovery
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RESIDENTIAL TREATMENT REFERRAL FORM

Name of Referrer: _____
Referring Agency: _____
Phone #: _____
Fax #: _____
Reason for Referral: _____
_____

Legal Guardian: _____
Relationship: _____
Phone #: _____
Address: _____
_____

Client Name: _____
DOB: _____
Age: _____
Gender: _____
Address: _____
_____
Insurance Provider: _____
(if OHP, please specify which CCO)

Previous Residential Tx (Y/N): _____
Dates: _____
Readmit (Y/N): _____
MH, SUD, or Dual Dx: _____
Systems Involved (Y/N): _____
Caseworker or PO (if applicable):
_____
_____

Date of Last Mental Health or Substance Use Assessment + Provider: _____
Precipitating Factors for Seeking Treatment: _____
_____
All Hospitalizations (Current/Previous): _____
_____
Current Medications: _____
_____

List of all Behavioral Health and/or Substance Use Tx Providers *(start with most recent)*:

Provider	Service	Start/End Dates	Reason for Completion

CLINICIANS/FACILITIES – PLEASE INCLUDE THE FOLLOWING DOCUMENTATION: MOST RECENT ASSESSMENT, CURRENT TREATMENT PLANS, FIVE (5) MOST RECENT CHART NOTES, ANY RISK ASSESSMENTS OR SAFETY PLANS.