REFERRAL FORM

Foothills Recovery
365 Foothills Academy Road
Albany, KY 42602
phone: 606-388-4607
fax: 606-387-4509
ssimmons@cbiky.org

Please fill out this form and e-mail, or fax to our office.

Client Information

Client's Name: _____ Age: _____

Client's DOB: _____ Clients SS#: _____ Phone: _____

Address: _____

Insurance: Yes / No Name of Insurance Carrier (if known) _____

Client Email (if known):_____

Referral Source Information

Referred by: _____ Date: _____

Title/Agency: _____ Phone: _____ Email: _____

Reason(s) for Referral/Client Needs:

_____

_____

Substances Used/Date of Last Use: _____

Legal Issues/Charges/Court Dates: _____

History of Violence: Yes / No Explain: _____

Previous Treatment: _____

Medications: _____

To Be Completed by Foothills Recovery Employee

Staff receiving referral: _____ Date staff responded to referral: _____

Comments/ActionTaken:_____

_____

_____

Date Intake Scheduled: _____ Therapist: _____