CONASAUGA COMMUNITY ADDICTION RECOVERY CENTER

Email completed form to mbeavers@whitfieldcountyga.com

REFERRAL FORM

Date of Referral: _____ /_____ /_____ *(DD-MM-YYYY)*

Is client aware of and agreeable to this referral? □ Yes □ No

Is this referral urgent? □ Yes □ No

CLIENT INFORMATION:

Name: _____

Last First Middle Initial

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Parent/guardian (if under 18 years): _____

Address: _____

City: _____ Province: _____ Postal Code _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____

May we email? □ Yes □ No **Note: Email is not considered a confidential medium of communication.*

REFERRING PROFESSIONAL:

Name: _____

Last First Middle Initial

Practice: _____

Address: _____

City: _____ Province: _____ Postal Code _____

Phone: _____ Fax: _____

E-mail: _____

CONASAUGA COMMUNITY ADDICTION RECOVERY CENTER

REASONS FOR REFERRAL (PRESENTING PROBLEMS):

ANY RELEVANT MEDICAL OR PSYCHIATRIC HISTORY?

ANY HISTORY OF AGGRESSIVE BEHAVIOUR AND/OR SELF HARM?

OFFICE USE: RECEIVED BY:

Counselor signature *Date*