

**RESIDENTIAL and DAY TREATMENT
REFERRAL COVER SHEET**

REFERRAL DATE: / / DAY TREATMENT RESIDENTIAL TREATMENT
 DD MM YYYY

REFERRING PARTY INFORMATION			
Agency Name			
Staff Name			
Staff Phone #		Staff E-mail	

CLIENT INFORMATION	
Client Name	
Client DOB	
Client Phone #	Client permission to call? <input type="checkbox"/> Yes <input type="checkbox"/> No Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Client E-mail	
Client Address	
Client Gender	

ASSESSMENT INFORMATION
NOTE: Standardized assessment (GAIN Q3 MI ONT or ADAT) is required.
GAIN Q3 MI ONT completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (Edited/final Recommendation & Referral Summary and Diagnostic Impressions Report must be attached)
ADAT completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (ADAT Tracking Summary, DHQ and Health Screening Form must be attached)
Have there been any significant changes in the client's substance use pattern, health status or living situation since the assessment was completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe: _____

ADDITIONAL RELEVANT INFORMATION	REFERRAL CHECKLIST
	<input type="checkbox"/> Consent to release/obtain info complete & attached <input type="checkbox"/> Referral cover sheet completed <input type="checkbox"/> Assessment complete & attached Note: A Well-Being form will be sent after client is given an admit date