AVITA COMMUNITY PARTNERS

Women's Treatment & Recovery Support Referral Form

Date of Contact: _____ Time of Contact:_____

Face-to-Face ____ Telephone ____ Mail/E-Mail ____ Other _____

Consumer's Name: _____ Phone#:_____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Sec.#: _____

Marital Status: _____ Race: _____

Referring person: _____

Relationship/Agency: _____Phone#: _____

Substance(s) of use: _____

Date Last Used: _____ Route of Administration: _____

Are there any medications taken daily? Yes/No

If yes, what? _____

Medicaid: Yes/No Other Insurance: Yes/No Provider: _____

History of Mental Health diagnosis and/or treatment: _____

_____

Are you on probation? Yes/No Probation Officer: _____

County: _____ Probation Officer's Phone#:_____

Are you currently pregnant? Yes/No If yes, how far along?: _____

Do you have any children 12 years of age or younger? Yes/No How many?: _____

Do you have an open Child Protective Services Case w/ DFCS? Yes/No

Case worker's name: _____ County: _____

Referral Taken By: _____

WTRS Employee

Additional Information:

Referral Taken By: _____

WTRS Employee