212 E Osborn Road, Phoenix AZ 85012
Phone: (602) 248-0368   Fax: (602) 761-2876

REN SELF REFERRAL FORM

Eligible individuals that complete an intake become REN members and are therefore qualified for all services REN provides. As a REN member, individuals can participate in groups, classes, community activities, and 1 on 1 peer support.

Please indicate a recovery goal you are seeking to achieve as a member of REN

Recovery Goal**:** ____

Applicant Name**:** ____

Preferred Name**:** ____

AHCCCS ID: ____

Guardian Name: ____

Guardian Phone:____________________ Guardian Email:________________________________

Address: ____ APT #: _________________

City**:** ______________________ State: _______________ _Zip Code: ___________________

Phone: ______________________________ DOB: __________________________________

Email: ____

By Signing below, I give permission for REN and my clinical team to communicate regarding my coordination of services. I also give REN permission to contact me by any means of communication listed above and to leave a message if necessary.

Applicant/ Guardian Signature: ____

Check the applicable box indicating eligibility:

☐ TXIX SMI

☐ NTXIX SMI

☐ GMHSU/ACC (Skip to Page 3)

Clinic Name**:** ____

Clinical Team Representative Name: ____

Title**:** _________________________ Supervisor Name: __________________________

Clinic State: ____________________ PNO: _____________________________________

Phone: ________________________Email: _____________________________________

Diagnostic Code**:** ____

Clinical Staff Signature: _______________________________________ Date:___________

(By Signing you are providing authorization for REN to provide services to the person listed above.)

Please include the following documents to complete the referral and authorization for services and fax to (602) 761-2876 or email to membership@renaz.org.

- Demographic form or Face Sheet
- Most recent Part E (Assessment) with BHP signature or Affidavit
- Most recent Individual Service Plan ISP (Must be signed by individual or guardian)

Member services manager will contact the applicant for membership activation upon receipt of the documents listed above.

REFERRAL QUESTIONNAIRE

Are you currently on probation/parole? **YES** **NO** (Circle One)

If "YES", Probation/Parole Officers Name: ____________________________________

Phone**:** _________________________ Email: _________________________________

Do you authorize REN to share your medical health information to your probation/parole officer?

If "NO" Initial Here ____________

If "YES" Signature Here ____

Are you a registered Sex Offender? **YES** **NO** (Circle One)

Is this Court Ordered Treatment? **YES** **NO** (Circle One)

Are you represented by an Advocate from the office of Human Rights?

YES **NO** (Circle One)

If "YES" Advocates Name: ____

Phone: ________________________Email: ____________________________________

Gender Identity:

- ☐ Women
- ☐ Man
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Non-Binary
- ☐ Other: ____________

Psychiatric Diagnosis (DSM V):

- ☐ Major Depressive Disorder
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Generalized Anxiety Disorder
- ☐ Schizoaffective
- ☐ Other: _____________
- ☐ Substance Use (Type _______________________________________)