SLV Recovery LLC
719-588-3227
slvrecoveryllc@gmail.com

Referral Form

Date: **March**/ / **2024**

Resident Name: D.O.B: / / Phone Number:

Referring Party Full Name: Phone:

Email Address: Organization/Agency:

Resident Information:

Gender: **Male** Race: **Hispanic** Ethnicity: **Hispanic**

Referral Circumstances (Which of the following were involved in the incident) check all that apply:

☐ Homeless ☐ Transitioning from Treatment facility
☐ Transitioning from DOC or jail ☐ Transitioning from Community Corrections
☐ Condition of probation/parole ☐ Judicial system
Other:

Resident'scriminal history at time of referral:

☐ Admitted drug use ☐ Distribution ☐ Possession ☐ DUI's ☐ DUID's ☐ Intent to sell Narcotics
☐ Pending Drug Charges Other:

Resident's Substance use history (Check all that apply):

☐ Alcohol ☐ Ecstasy ☐ Methamphetamines ☐ Fentanyl
☐ Benzodiazepine ☐ Heroine ☐ Misuse of prescription ☐ Xylazine
☐ Cocaine/Crack ☐ Marijuana ☐ Opioids Other

Date of Last Use:

Currently Involved in AOD/SUD Services?

☐ Yes ☐ No
Provider:

Mental Health Concerns:

Mental Health Treatment:

☐ Yes ☐ No
Service provider**:** Last date of Service:
If Hospitalized When: Where:

Suicide Concerns:

Previous attempts ☐ Yes ☐ No
Suicidal Ideations ☐ Yes ☐ No Date(s):
If Yes Date(s): Current Concerns: ☐ Yes ☐ No

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Summary/Reason for referral: Specific details and dates of the above checked boxes, include AOD/SUD related history as well as treatment episodes, arrests, CPS, family, & domestic violence, and current drug test results including failure to test (s).

Signature of Resident (Print) Date

Signature of Resident Date

Signature of Referring Party Date