**Recovery Services Unlimited-**

**Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Customer Name: |  | Last 4 of SSN: |  |
| Phone Number: |   | DOB: |  |
| Address: |  |

|  |
| --- |
| Primary Clinician: |
| Clinician Contact Information:  |  |  |  |
| Primary SUD Diagnosis:  |  | Diagnosis Code: |  |

|  |  |
| --- | --- |
| Treatment Recommendations (Please indicate if you are recommending Recovery Housing, Recovery Coaching, and/or Outpatient SUD Services): |  |
| Outpatient SUD Provider Discharge PlanOutpatient SUD Provider:Name of Clinician:Intake Appointment Date and Time: |  |
| Other Information: |  |

**Please Fax** Referral Form, Release of Information, ASAM Continuum Assessment and Treatment Plan to **(269) 397-2261** or please call (269) 234-3186 if you have any questions or need any assistance!