



JOURNIES INC.

700 36th Street, Ste. 106
Grand Rapids, MI 49548
Phone: 616.774.7002
Fax: 616.774.7007

Client Referral Form

Client Name: _____ Phone: _____
Date of Birth: _____
Conviction: _____ BAC: _____
Probation Start: _____ Probation End: _____

Reason for Referral:

- Substance Use Assessment \$115
- Substance Use Assessment with Drug Screen \$135
- Impulsivity Group \$115
- First Offenders Group \$115
- Retail Fraud Group \$115
- Crossroads Group (8 AOD education sessions) \$385
- Individual Counseling in English or Spanish \$80 per session
- Intensive Outpatient Group \$735
- Relapse Prevention \$35 per session
- Women's Group \$35 per session
- MADD VIP Impact Panel in Spanish \$35 per session
- Drug Test (instant stick test)

If referring for drug test, select which type:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> THC \$15 | <input type="checkbox"/> ETG \$15 | <input type="checkbox"/> THC + ETG \$20 | <input type="checkbox"/> 8 Panels \$30 |
| <input type="checkbox"/> 8 Panels / ETG \$35 | <input type="checkbox"/> 12 Panels \$35 | <input type="checkbox"/> 12 Panels / ETG \$35 | <input type="checkbox"/> Lab \$35 |

Referred By: _____ Court: _____
Appointment Date: _____

I, _____, hereby authorize Journies Inc., its director or designee(s), to release information to, and to receive information from, _____. The extent and nature of the information will concern my attendance and progression in the program and, if needed, recommendations outside of Journies Inc.'s facility. The purpose of this disclosure is to assist the referring agency in reaching a satisfactory disposition of my case. The authorization will remain in effect until the purpose for which it was given no longer exists. In the case of criminal justice referral, the authorization will expire when the program receives official written notice of a change in my legal status.

Client Signature: _____ Date: _____

Referring Agent Signature: _____ Date: _____