



# Community Recovery Center Referral

Please provide the following information and send this information to Wautoma Behavioral Health Services at FAX: 920-787-4737 or call at 920-787-5514 EXT 416 (**Contact will be made within 24 hours of referral**)

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Referred by:\*

Name \_\_\_\_\_ Agency \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Home Phone: ( ) \_\_\_\_\_ May we leave a message?  Yes  No

Cell/Other Phone: ( ) \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender:  Male  Female SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Race: \_\_\_\_\_

Marital Status:  Never Married  Domestic Partnership  Married  Separated  Divorced  Widowed

Drug (s) of Abuse: \_\_\_\_\_ Last Use: \_\_\_\_\_

IVD User:  Yes  No On Probation/Parole  Yes  No

Is this person pregnant?  Yes  No

Services requested: \_\_\_\_\_

Current enrollment in any other programs: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_

Relationship to you? \_\_\_\_\_ Telephone Number \_\_\_\_\_

Insurance Company Name and Address: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Group Number \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_ Date of Birth (if other than self): \_\_\_\_\_

**\*Please note: Email correspondence is not considered to be a confidential medium of communication. Please attach a reciprocal confidential release of information to this referral**