



Community Recovery Center Referral

Please provide the following information and send this information to Community Recovery Center Services, by phone 608-474-4355, or via encrypted email to Recovery.Referrals@famhealth.com (**Contact will be made within 1 business day**).

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**