

**RECOVERY CASE MANAGEMENT REFERRAL**

**Date:**

**Referral Source:**

Referring Program or Agency:       Phone:

Referring Staff Name:

**Application Information:**

Applicant’s Name:       Phone:

Address:       City:       State:       Zip:

D.O.B.:       Social Security #:       Gender: [ ]  Male [ ]  Female [ ]  Other:

Care Manager or ICM:       Residential Counselor:

**Current Residence:** (Check One)

|  |  |  |  |
| --- | --- | --- | --- |
| **Check** | **Type of Housing** | **Program Name (if applicable)** | **Move in Date** |
| [ ]  | Community Residence |       |       |
| [ ]  | Supervised Apartment |       |       |
| [ ]  | Own Home or Apartment |       |       |
| [ ]  | With Family/Friends |       |       |
| [ ]  | Other |       |       |

**Reason for Referral to RISE Support Services:**

**Current Treatment Contacts:**

Psychiatrist:       Phone Number:

Therapist/Counselor:       Phone Number:

Addiction Counselor:       Phone Number:

**Current Diagnosis:**

**Drug and Alcohol History:**

Age first used drugs/alcohol:       Date of last use of drugs/alcohol:

Which substances used/abused? List all alcohol/illegal drugs used:

Substance of choice (including alcohol):

Describe history of treatment (treatment sources, dates of treatment) :

     Describe current support/treatment (eg. AA, NA, PROS, SCASAS, SPARC, etc.):

**Family/Community Contacts:**

Name:

Address:

Phone Number:

Relationship:

Name:

Address:

Phone Number:

Relationship:

**Additional Information (as available):**

1. Copy of psychosocial assessment

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Signature of Applicant Date

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Signature of Referral Source Date

Attention: PSAP Program Director

Phone: (518) 587-2115

Fax: (518) 587-8703