REFERRAL FORM

Prevention Links Recovery Community Development Services / RESTORE Program

CONFIDENTIALITY NOTICE
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To *(check one)*:

__ Prevention Links – Recovery Community Development Division
Jewel Savvides, Recovery Engagement Manager
Email: jsavvides@preventionlinks.org
Phone: 201-589-8509

__ Urban Workforce Advantage
Yunia Labaut
Phone: 908-355-2288
Fax: 908-355-2239
Email: ylabaut@workforceadvantageusa.com

From: _____

Date: _____

Services Requested:

☐ ***Job Development***
Re-Employment Support and Training for the Opioid Related Epidemic (RESTORE) Program – *Vocational training program that supplies specific skills courses, job placement assistance, and vocational support for any individual affected directly or indirectly by opioid use.*

☐ ***Recovery Support Services***
Re-Employment Support and Training for the Opioid Related Epidemic (RESTORE) Program – *Peer Recovery Support provided to those directly and indirectly affected by opioid use; includes peer mentorship services, non-clinical case management services, individual recovery planning, family support services, and referral when appropriate.*

Participant Name: _____ Date of Referral: _____
This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law Federal Regulations and Statutes (42 CFR- Part 2) and New Jersey State Statutes (N.J.S.A. 26:2b-15) prohibits you from any further disclosure of it without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations and statutes. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Participant Phone: (_____) _____-_____ **Participant Email: _____**

Referrer Name: _____ **Referrer Agency: _____**

Referrer Phone: (_____) _____-_____ **Referrer Email:_____**

Participant Information

DOB: _____ **Municipality: _____**

Race: _____ **Probation/Parole? Y____ N____**

Sex: M ____ F ____ Other _____ **Currently in Treatment? Y____ N____**

Treatment Provider: _____

Medications: _____

Diagnoses: _____

Other pertinent information:

_____

_____

_____

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