Provider Referral Form

1. **Date of Referral:** _____/_____/_____

2. **Referral Source Name**: _____

3. **Participant Information:**

   Name: _____

   Phone: (___) _____

   Permission to leave a voicemail identifying agency? _____ Yes _____ No

   Date of Birth _____/_____/_____ **Age:** _____ **Gender:** ____ Male/ ____ Female/_____ NB_____

   County of Residence: _____ **Employment Status:** _____

4. **Services Interested in (Please check ALL that apply):**

Peer Recovery Support

Peer Recovery Family Support

Employment Case Management &/or Employment Certifications

Other: _____

5. **Currently involved with mental health treatment?** _____ Yes _____ No

   If yes, please specify: _____

6. **Currently involved with substance use treatment?** _____ Yes _____ No (i.e. detox, IOP, OP, MAT, or residential)

   If yes, please specify: _____

(cont'd)

7. I, _____, authorize _____ to release the above information to Prevention Links Recovery Community Development Division. I understand a representative of Prevention Links will contact me prior to my participation in their program (s). All the information contained is accurate.

Participant's Signature: X: _____	**Date:** _____/_____/_____
Signature of person making referral (if other than consumer): X: _____	**Name of person making referral: (please print)** _____

Please mail or email referral to:

Prevention Links- Recovery Community Development

Attention: Cindymarie Dix

121-125 Chestnut Street, Suite 301, Roselle, NJ

Phone: 917-757-7958
Email: RCDD@preventionlinks.org

Other comments/relevant information:

_____

_____

__

For Administrative Use Only:

Outreach Conducted on: _____/_____/_____ By *(Initials)*: _____

Program Eligibility: _____

Intake set for: _____/_____/_____

Recovery Community Development Provider Referral Form ***Created on 07/21/21***