Dual Recovery Program
321 West Onondaga Street, suite 201
Syracuse, NY 13202
P: (315)478-0610
F: (315)478-2510

Referral Form

Please share with us the following information:

Date_____________

Name: (First, Last, MI) ____DOB: ___________________________________

Are they known by any other name (Alias or Maiden Name): ____

Gender: Male ________ Female ______ Social Security #: ____

Marital Status: Never Married ________ Married________ Widowed ________ Separated _________________________

Address: ____

____Okay to send mail?_________________________

Home Phone #: _____________Work Phone #: ______________Cell Phone#: ______________

Email Address: _______________________________________

Are there any special calling instructions? ____

Emergency Contact Name: ____

Emergency Contact Address: ____

____Phone number_________________________

What is their relationship to this person: ____

Health insurance provider: (Insurance, Medicaid, Self-Pay): ____

Member ID/CIN # (if available):___________________________

**PLEASE TELL THEM TO BRING IN THEIR INSURANCE CARD, MEDICAID CARD OR MEDICAID PENDING LETTER OR IF THEY DO NOT HAVE INSURANCE AND NEED TO BE ON A SELF-PAY SLIDING FEE, TO BRING IN PROOF OF THEIR INCOME (PAY STUBS, W-2,) AND BE PREPARED TO PAY TOWARD A FEE.

**PLEASE NOTE THAT WE WILL BE UNABLE TO SEE ANYONE WHO DOES NOT HAVE SOME FORM OF PAYMENT OR IS NOT AT LEAST MEDICAID PENDING WITH THEIR PENDING LETTER

Why are you referring them? ____

____

What substances (Alcohol, Drugs, Prescriptions) are they using/abusing? And last date of use reported? ______________

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Does this individual have a Mental Health Diagnosis? ____

____

Are they receiving services from any other provider? ____

Referral Agency: ______________________Contact person: ______________________

Phone #: ______________________

**If you do not have all of the information, please indicate "unknown" and fax it to 315-478-2510. Thank-You!

Any Additional Information that may be helpful to the clinician and Treatment Team while assessing this individual:____

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Contact Information for Person Completing Referral:

Name: ______________________ Title: ______________________

Organization: ____

Address: ____

Phone: ______________________ Email:______________________