WellStone
Connect to health & well-being

River Valley Recovery Center
Referral Form

Date of Referral: _____

Referring Provider Name: _____ Agency: _____

Phone: _____ Fax: _____

Please Attach: Intake ASAM, Update Psychosocial Assessment, Labs, Recent TB Results, Urine Sample Results, Treatment Plan, Progress of Client, Client Status, COVID Test Results

Client Demographic Information

Name: Last_____ First_____ Middle: _____ Preferred Name: _____
DOB: _____ Social Security #: _____
Address: _____ City: _____ State: _____
ZIP CODE: _____ PHONE: (___) _____
Gender: ○ Male ○ Female ○Transgender Male/Transman ○Transgender Female/Transwoman ○non-Binary
○ Gender Neutral ○ Other _____ Identifying Pronouns: _____
Sex at Birth: ○Male ○ Female
Race: _____ Marital Status: _____
Language: _____ Interpreter: ○ No ○ Yes
Insurance Type: _____ Group #_____

Clinical Information

Reason for Referral:
_____
Primary Care Physician:
_____
Phone: _____
Fax: _____
Presenting Problems: _____
_____
_____
_____

Clinical Features

1. Suicidality:
Ideation: ○ No ○ Yes if so ○ Active ○ Passive
Plan: ○ No ○ Yes: _____
Attempts: ○ No ○ Yes:
_____
2. Self-Harm Behavior:
Current? ○ No ○ Yes: _____
Toward others? ○ No ○ Yes: _____
Towards property? ○ No ○ Yes: _____

River Valley Recovery Center Staff Only

Date: _____
○ Appropriate for services due to meeting criteria.
○ Is not appropriate for services currently due to not meeting service criteria.
○Referral provided to the following:
○ Agency: _____ Phone: _____ Fax: _____
○ Agency: _____ Phone: _____ Fax: _____
○ Agency: _____ Phone: _____ Fax: _____

Employee Signature: _____ Date: _____