REFERRAL FORM

DBHIDS/ OAS Recovery House Initiative | Email: OAS-RHReferral@Phila.gov|

City of Philadelphia DBHIDS Department of Behavioral Health and Intellectual disAbility Services

Instructions: Please fill out and submit one form per person to the Recovery House Initiative

Does this individual gives consent provide the information below? ☐ Yes ☐ No

if no, please stop filling out this form

Participant's Information

Participant's First Name: _____

Participant's Last Name: _____ **Date of Birth:** ___/_____/_____

Gender (*please select one*):
☐ Male ☐ Female ☐ Transgender MTF ☐ Transgender FTM
☐ Intersex ☐ Gender Queer ☐ Other: _____

Type of funding?
☐ CBH ☐ BHSI ☐ VA ☐ Other: _____

Is substance use disorder the primary diagnosis?
☐ Yes ☐ No
If yes, please list the substance(s):
_____

Anticipated Successful Discharge Date:
_____/_____/_____

What was or is their current living situation prior to treatment? (please select one):
☐ Street (Homeless) ☐ Living with Family/Friends ☐ Shelter ☐ Safe Haven ☐ Living Alone/Independent
☐ Correctional Institution ☐ Other: _____

Does this referral participate in MAT? ☐ Yes ☐ No
If yes, please specify:
☐ Methadone ☐ Suboxone ☐ Vivitrol/Naltrexone

Any ongoing medical issues? ☐ Yes ☐ No
if yes, please specify:

Issue(s):	Medication(s):
1.	
2.	
3.	
4.	

Is there a mental health diagnosis? ☐ Yes ☐ No
If yes, please specify: _____
Medication: _____

Any involvement with the criminal justice system?
☐ Yes ☐ No
If yes, Status/Charge: _____
☐ State ☐ Federal (please select one)
PP ID: _____

Is this person Spanish speaking only? ☐ Yes ☐ No

Does this person need family housing? ☐ Yes ☐ No
If yes, Gender: _____ **Child Age:** _____
Gender: _____ **Child Age:** _____

Are there any areas in the city to avoid when referring?
_____

Outpatient Treatment Provider:
_____

Case Manager's Name: _____
Phone Number: (____) – _____– _____

Case Manager Type (please select one):
☐ FIR ☐ ICM ☐ BHSI

Referral Source Information:

Referral Source Name: _____ **Date:** _____
(Last Name, First Name)

Email Address: _____

Agency: _____ **Phone Number:** _____

***For DBHIDS/OAS Staff Only*:**

Project Assistant Review: _____ Signature _____ Date

Project Supervisor Review: _____ Signature _____ Date

Referred to: Agency: _____ Program: _____