REFERRAL FORM

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

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

Does this individual give consent to 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: ________________________________

Participant's Social Security Number: ________________________

Participant's Race: African-American Caucasian/White Asian/Pacific Other: ____________

Participant's Ethnicity: (please select one)
Hispanic Non-Hispanic

Gender (*please select one*):
☐Male ☐Female ☐ Transgender MTF ☐ Transgender FTM
☐Intersex ☐ Non-Binary ☐Other: _________________________

Date of Birth: ____________

Type of funding? (please select one)
☐CBH ☐ BHSI ☐ VA ☐ Other: ____________________

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

____

Is the participant currently in treatment ☐ Yes ☐ No

If yes, which type: ☐ Inpatient ☐ Outpatient

Anticipated successful discharge date? *(Inpatient Only)*:

____

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

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

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

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

Any involvement with the criminal justice system?
☐ Yes ☐ No
If yes, Status/Charge: __________________________
☐ State ☐ Federal ☐ County (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: _______________________________________
(Last Name, First Name)

Date: ________________________

Email Address:________________________________

Agency: ____

Phone Number:_______________________________

For DBHIDS/OAS Staff Only:

Project Assistant Review:	________________________ Signature	__________ Date
Project Supervisor Review:	________________________ Signature	__________ Date
Referred to:	**Agency:** _____________________	**Program:** _________________________