

**Cristo Rey Behavioral Health and Prevention Services**

1717 N. High St., Lansing, MI 48906  
(517)372-4700 ext. 140, Fax (517)372-3314

**REFERRAL FORM**

**PLEASE PRINT ALL INFORMATION**

IMPORTANT: Please have the client bring this form to Cristo Rey for the first appointment

Referring Agency, Referring Agent Name, Number and Fax: \_\_\_\_\_

Client (Full) Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City, State, and Zip: \_\_\_\_\_

Ph. # Home: \_\_\_\_\_ Work: \_\_\_\_\_ Social Security No. \_\_\_\_/\_\_\_\_/\_\_\_\_

*Referring agency has made initial contact and/or scheduled appointment on:*

\_\_\_\_\_, with: \_\_\_\_\_

**REFERRAL TO:**

ENGLISH  SPANISH

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> Anger Management Program                      | <input type="checkbox"/> Cognitive Behavioral Therapy                    | <input type="checkbox"/> Domestic Violence Program | <input type="checkbox"/> Family Drug Court  | <input type="checkbox"/> Intensive Out-Patient Program                   |
| <input type="checkbox"/> Living Free Women's Substance Abuse Treatment | <input type="checkbox"/> Parent Nurturing Program                        | <input type="checkbox"/> PBT's and Urine Screens   | <input type="checkbox"/> Sobriety Court     | <input type="checkbox"/> Strengthening Families--Roots and Wings Program |
| <input type="checkbox"/> Substance Abuse (Assessment Only)             | <input type="checkbox"/> Substance Abuse (Intake for Treatment Planning) | <input type="checkbox"/> Substance Abuse Treatment | <input type="checkbox"/> Youth SURF Program |  |

**Court/Agency:** District \_\_\_ Circuit \_\_\_ Family \_\_\_ CPS \_\_\_ Other \_\_\_\_\_

Alcohol Related: \_\_\_ BAC: \_\_\_ Drug related (specify): \_\_\_\_\_

Arrest/Conviction: Drunk Driving \_\_\_ Domestic \_\_\_ Other \_\_\_\_\_

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**RELEASE AUTHORIZATION AGREEMENT**

I authorize Cristo Rey Behavioral Health and Prevention Services, to release information. The extent and nature of this information will concern my attendance, participation level and progress in the program and when necessary offer recommendations for additional referrals. The purpose of this disclosure is to assist the referring agency in reaching a satisfactory deposition of my case. This authorization will remain in effect until the purpose for which it was intended no longer exists or when the program receives written notice of change in my status. In addition, I hereby agree to attend and satisfactorily complete the program according to the rules and regulations. I am aware that my case may be terminated with approval from the Program Coordinator when program rules and regulations are not adhered to. This may be done in written or in verbal form without prior notification.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part2; The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; and the Mental Health Code, Section 330.1748 of Public Act 258.

\_\_\_\_\_  
**Client's Signature** **Date**

\_\_\_\_\_  
**Witness Signature** **Date**

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**PROGRAM RESPONSE: Client contact, (appt. date, assigned placement, start date, etc).**

\_\_\_\_\_

\_\_\_\_\_  
**Reporting Person's Signature**

\_\_\_\_\_  
**Title/Position**

\_\_\_\_\_  
**Date**