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

☐ Anger Management Program
☐ Cognitive Behavioral Therapy
☐ Domestic Violence Program
☐ Family Drug Court
☐ Intensive Out-Patient Program
☐ Living Free Women's Substance Abuse Treatment
☐ Parent Nurturing Program
☐ PBT's and Urine Screens
☐ Sobriety Court
☐ Strengthening Families--Roots and Wings Program
☐ Substance Abuse (Assessment Only)
☐ Substance Abuse (Intake for Treatment Planning)
☐ Substance Abuse Treatment
☐ 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).

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______________________________ _________________________________ ________________________
Reporting Person's Signature **Title/Position** **Date**