Referral List Form

Please fill out this form and fax it to 773-883-3882. If you have any questions, please call our main line and speak to the intake coordinator: 773-883-3916.

Physician Name/Treatment Center/Therapist Name: ____

Street Address: ____

City:_____________________________State:____Zip:_________________Country: ______________________

Office Phone:___________________________________Office Fax: ___________________________________

Level of Care:

□ Residential
□ Aftercare
□ Individual Counseling
□ Partial Hospitalization
□ Halfway House
□ Vocational Therapy
□ Intensive Outpatient
□ Medical Detoxification
□ Other ____________________

Specialty:

□ Dual Diagnosis
□ Women/Child
□ Criminal Justice
□ Eating Disorders
□ Homelessness
□ DUI/DWI Offenders
□ Language _________________
□ Couples
□ Other ____________________

Forms of Payment:

□ Self Pay
□ Medicaid
□ Sliding Scale
□ Medicare
□ Free
□ Private Insurance

Age Group:

□ Child (0-12)
□ Adult (27-59)
□ Adolescent (12-17)
□ Older Adult (60+)
□ Emerging Adult (18-26)