PEER RECOVERY SERVICES REFERRAL FORM

Please send this form + *MDHHS Consent to Share Behavioral Health Information* form to: referrals@careofsem.com

Referring treatment provider: ____________________________________

Date of referral: ______________________

REFERRED INDIVIDUAL'S INFORMATION

Name: ____ **DOB:** ______________ **Gender: M / F**

Admission date: ________________ **Discharge date:** _______________

Phone Number: ____

Resident Address: ____ **City/Zip code:** _________________________

□ **Macomb County Resident** □ **Returning to Macomb County (planning to relocate)**

□ **Permanently resides/plans to reside outside of Macomb County | Where:** ______________________________

List Drug(s) of Choice: ____

Please check all that apply:

□ **Individual has children under the age of 18 that they provide for** □ **Individual is pregnant**

□ **Individual is enrolled in Medicaid/Healthy Michigan** □ **Individual is uninsured**

□ **Individual has other insurance type:** ____

□ **Individual needs outpatient services** □ **Individual is on MAT:** ________________________

IF WE HAVE QUESTIONS ABOUT THIS REFERRAL, WHO CAN WE CONTACT?

Name: ____ **Relation:** _________________________________

Phone Number: ______________________________ **email:** ____

Other information relevant to the referral: