Cherry Health
Comprehensive. Quality. *Healthcare.*

Community Recovery Programs Referral

Date:	**Contact Person:**	**Phone Number:**
Client Name:	**DOB:**	**Insurance:**
Address:		**Phone:**
Primary Care Physician:		
Reason for Referral and Additional Information:		
Mental health concerns(please include trauma) and Substance use or mental health treatment history		
Drugs of Choice:	**Date of Last Use:**	**Frequency of Use:**
1.		
2.		
3.		
Children living in the home:	**DOB:**	**Relationship:**
1.		
2.		
3.		
4.		
Children <u>not</u> living in the home:		
1.		
2.		
3.		
Other adults in the home:		
1.		
2.		
Any children born drug-exposed?	**Is the client currently pregnant?**	
☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A	
Court Involvement:		
Criminal Court: ☐ Yes ☐ No	**Family Court:** ☐ Yes ☐ No	

Please send all referrals to **CommunitySUDReferrals@cherryhealth.com**