People, Places, and Dreams
Peer • Wellness • Recovery

Client Referral Information

Date: _____ **Client ID:** _____

Referring Source: _____

Referring Doctor/ Agency: _____

Phone: _____

Email: _____

Client Name:_____

DOB: _____ **Social Security Number:** _____

Is client their own legal guardian? ☐ Yes ☐ No

If no, name of legal guardian: _____

Client/ Legal Guardian Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Email: _____

Emergency Contact:_____ **Phone:** _____

Relationship to Client:_____ **Permission to Contact: Y N**

25201 Chagrin Bld., Suite 390, Beachwood, OH 44122
Office (216) 910-9015 Fax (216) 910-9015
www.peopleplacesanddreams.

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Primary Insurance: _____

Group #: _____ **MMIS #:** _____

Criminal Record ☐ Yes ☐ No (If yes, please explain): _____

SUD Diagnosis: Dx_____ **Dx**_____ **Dx**_____

MH Diagnosis: Dx_____ **Dx**_____ **Dx**_____

Medical Conditions (pertinent to care): _____

_____

Medications (pertinent to care): _____

MAT: ☐ Yes ☐ No (If yes, please give medication and dosage): _____

Social Services Involvement (pertinent to care): _____

Environmental Conditions (pertinent to care): _____

_____

Financial Conditions (pertinent to care): _____

_____

Criminal Justice Involvement (pertinent to care): _____

_____

Case Manager: _____

Phone: _____ **Fax:** _____

Counselor: _____

Phone: _____ **Fax:** _____

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Current Symptoms/ Behavior Observations (please circle all that apply):

Anxiety/ Stress	**Anger**	**Substance Use**	**Opioid Use/ Heroin Use**
Marijuana Use	**Impulsivity/ ADHD/ ADD**	**Depression/ Hopelessness**	**Relationship Concerns/ Abuse**
Alcoholism	**High Risk Activities**	**Benzo Use**	**Meth Use**
Cocaine/ Crack Use	**Gambling Addiction**	**Co-Occuring Disorders**	**Court Ordered**

Services Requested:

Peer Supportive Services	**Recovery Housing**	**Needs Assessment**	**SUD Assessment**
Case Management	**Peer Group**	**Marijuana Program**	**Gambling Initiative**
Parenting Class			

A determination as to the most appropriate services for each client will be made based on this information. It is important to know as much as possible about each client. We ask that you provide as much information as possible, so we can make an accurate assessment of services needed.

Please fax referral forms to:

216-910-9015

Attn: Intake Coordinator

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