People, Places, and Dreams
Peer • Wellness • Recovery

Client Referral Information

Date: _____

Referring Source/Agency/Doctor: _____

Phone: _____ **Email:** _____

Name:_____

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

Address:_____

Phone: _____ **Email:** _____

Legal guardian? ☐ Yes ☐ No (If yes, name of legal guardian) _____

Primary Insurance: _____ **No Insurance: ☐ Yes ☐ No**

Do you smoke? ☐ Yes ☐ No: If so, what? _____

Social Services Involvement/ Environmental/ Financial/ Criminal Justice Involvement: (pertinent to care): _____

Current Symptoms/ Services Requested (please circle all that apply):

Peer Supportive Services MH and SUD	Rose Quartz Women's Program	Smoking Cessation	MH/SUD Assessment Case Management/ Counseling	SOR- State Opioid Response/ Private Insurance
Intensive Outpatient (IOP)	Parenting Classes	MID Program (Marijuana/ MDMA) Harm Reduction	MAT Peer Support/ Perinatal MAT	LGBTQ Recovery Housing Referral

Attn: Intake Coordinator

1. Fax referral forms to 216-910-9015 or
2. Email: intake@peopleplacesanddreams.com

(Please allow 24-48 hours for response)

3214 Prospect Ave E, Cleveland, OH 44115 Office (216) 910-9015 Fax (216) 910-9015
www.peopleplacesanddreams.com