



Tel: 250-381-9474
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INCOMING REFERRAL FORM

Referral Date: _____

Name: _____ Phone Number: _____

Address: _____

Current living situation: _____

Referral Source: _____

Workers Name: _____ Phone Number: _____

DOB: _____ Age: _____ Male: Female:

Substance(s) requiring treatment: _____

Length of time since last use: _____ PHN: _____

Criminal Record? *Yes / No* If yes, please specify _____

Medical considerations: _____

Physician: _____ Phone Number: _____

Legal Guardian: _____ Phone Number: _____

Other emergency contact: _____

Other relevant information: _____

Scheduled arrival time: _____

Please Note: Client Intakes are done Monday through Friday between 10:00 am - 4:00 pm.