

STATE OF CONNECTICUT
ACCESS TO RECOVERY II PROGRAM (ATR II)
Department of Mental Health and Addiction Services

REFERRAL FORM SAMPLE

Instructions: Complete this form when referring a recipient to a community-based resource. The referral form should be completed in addition to a phone call to the program to which the recipient is being referred. A copy of the referral form should be given to the recipient to take with him/her and another should be kept in the recipient's chart. If a follow-up is required please ensure that a Release of Information form is completed between the ATR II provider and the agency to which the recipient is being referred.

Referring Agency: _____ Date: _____

Address: _____

Referring Staff: _____ Telephone Number: _____

Agency/Service/Program for Referral: _____

Reason for Referral:

Recipient's Name: _____ Birth Date: _____

Address: _____

Telephone Number: _____ Gender _____ M _____ F _____ Other

Other Relevant Information:
