Blair Drug and Alcohol Program, Inc.
Certified Recovery Specialist Services Referral

Date of Referral:_____

Name: _____ Cell Phone:_____

Address:_____ Home Phone: _____

_____ SS #_____

D.O.B. _____ Gender – M F, Veteran - Y N, IV User(IDU) Y N , Alcohol - Y N , Opiate - Y N
Stimulant - Y N, High Risk - Pregnant - Y N, Overdose Survivor - Y N , Other_____

Is the client employed? ___ _____No Employer_____

Does this client have insurance: Y N If yes, is it CCBH? Y N

Is the recoveree currently in treatment? Y N Where: _____

Is the individual in a Treatment Court? Y N Court: _____

If you are working with someone who is interested in CRS Services, please check all services of interest that apply below and fax this form to the Blair Drug and Alcohol Program, Inc. (fax # 814.381.0922). We will then contact the individual within one week to offer CRS services.

___ Accessing Community Resources

___ Recovery Education

___ Recovery Community Activities

___ Advocacy

___ Case Management referrals

___ Recovery Planning

___ Life Skills

___ Treatment Support

___ Recovery Support Groups

___ Telephone Recovery Support (Recovery Check-ups), complete information below:

_____

Reason for Referral to CRS Services: _____

_____

Person making referral: _____

Referral source phone number: _____

Attachment 05Da- CRS referral form

07/01/2020

Fax this form to:
Recovery Specialist 814-381-0922