



**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
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 Planning

___ Recovery Education

___ Life Skills

___ Recovery Community Activities

___ Treatment Support

___ Advocacy

___ Recovery Support Groups

___ Case Management referrals

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

Reason for Referral to CRS Services: _____

Person making referral: _____

Referral source phone number: _____

1/14/2020

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