

Referral Form

Date of Referral://	
Client's Name:	D.O.B//
MUST ATTACH FACE SHEET TO HERE)	REFERRAL (IF CORRECT PHONE IS NOT ON FACE SHEET – PLEASE WRITE
Phone:	_Alt. Phone:
Referent Information	
Physician Name:	
Office Number <u>:</u>	
Fax Number:	
Does client have insurance:	
	o be contacted by staff members at The Council
Reason for referral and any ad	litional comments to share with our team:

To refer your client to The Council:

- 1. Fax this Form to <u>281-200-9765</u>
- 2. Email to ckalinec@councilonrecovery.org

Thank you for your referral to The Council on Recovery!

or