THE COUNCIL
ON RECOVERY

Referral Form

Date of Referral: ___/___/___

Client's Name:_____ D.O.B. ___/___/___

MUST ATTACH FACE SHEET TO REFERRAL (IF CORRECT PHONE IS NOT ON FACE SHEET – PLEASE WRITE HERE)

Phone:_____Alt. Phone: _____

Referent Information

Physician Name: _____

Office Number:_____

Fax Number: _____

Does client have insurance:❑ Yes
❒ No

❒ Client has given permission to be contacted by staff members at The Council

Reason for referral and any additional comments to share with our team:

To refer your client to The Council:

1. Fax this Form to _281-200-9765_____ or
2. Email to ckalinec@councilonrecovery.org

Thank you for your referral to The Council on Recovery!