



2413 2nd Street
Eureka CA 95501
707-269-9590
fax 707-444-8012

Referral Form

Prospective Patient/Client*

Name _____ DOB _____

Phone # () _____ Address _____

City _____

Referral Source/Agency

Agency Name _____

Referring Person Name (Print) _____

Referring Person Phone () _____

Check List - must be completed

_____ Send all medical/mental health records to Waterfront Recovery Services for review.

_____ Inform the patient/client about the nature of medical model-based treatment including the potential need to take medications.

_____ Inform WRS of the case manager name _____ and phone number () _____ if different from the referring person.

_____ Establish an agreed-upon continuum of care plan for the patient/client after discharge back to county of origin.

****For Dual Diagnosis Patients/Clients, please complete page 2.***

Please return completed document to Waterfront Recovery Services with "ATTN: Admissions via mail, fax or as an email attachment to wrs.admission@gmail.com

WaterfrontRecovery.org

Additional Information Required for Dual Diagnosis Referrals

Name _____ DOB _____

Diagnosis/es _____ Date _____

Mental health provider(s) _____ Phone # _____

Last appointment: _____

Medications _____ Dosage _____ Frequency _____

Last refill _____ Medication Compliant Yes _____ No _____

2. _____
_____ Yes _____ No _____

3. _____
_____ Yes _____ No _____

4. _____
_____ Yes _____ No _____

If not currently medication compliant: Prospective patient/resident will need to be on medications for at least 2 weeks prior to admission. We will be checking the drug levels of the prescribed medications upon admission to WRS and will discharge them if results are not consistent with the list of medications reported.

Contacts coordinating with WRS Admission and Case Management:

Name/Title _____

Telephone # _____ FAX# _____

Email _____