



The POTTER'S HOUSE
Substance Abuse Center

“Rebuilding shattered lives physically, spiritually and emotionally”

REFERRAL FORM

Please print and completely fill out the form below, then fax, mail, or scan and email form back to agency. (one form per client)

Program/Officer: _____ **Location:** _____

Referring Agency Name: _____

Contact Person: _____ **Phone:** _____

Fax: _____ **Date of Referral:** _____

CLIENT INFORMATION:

Client Name: _____ **Client DOB:** _____

Client Contact Number: _____ **CASE #:** _____

Self Pay: YES NO

AHCCCS ID#: _____

PARTICIPATION INFORMATION: (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Substance Abuse Groups | <input type="checkbox"/> Individual Counseling Sessions | <input type="checkbox"/> DES/CPS Services |
| <input type="checkbox"/> Intensive Outpatient | <input type="checkbox"/> Anger Management Groups | <input type="checkbox"/> Parenting Skills Groups |
| <input type="checkbox"/> Relapse Prevention | <input type="checkbox"/> Community Service/Restitution | <input type="checkbox"/> Prevention & Outreach Services |
| <input type="checkbox"/> Domestic Violence Group | <input type="checkbox"/> MVD Revocation Packets for Reinstatement of Drivers License | <input type="checkbox"/> DUI Screenings for Reinstatement of Driver License |

Additional Comments: _____

Staff Signature: _____ **Date:** _____