DUAL RECOVERY REVIEW COMMITTEE REFERRAL REQUEST FORM

Client Name: _____ Date: _____

DOB: _____Social Security #: _____ Phone #: _____

Client Address: _____

Referral Source (Agency Supervisor): _____

Agency Supervisor Signature: _____

Primary Clinician/Case Manager: _____

Phone: _____ Fax: _____

This case has been reviewed to date as follows (circle Yes or No):

- **Case Conference at agency Y/N**
- **All Treatment Providers involved have met Y/N**
- **Other steps already taken to resolve the situation:_____**

Presenting Problem: _____

_____

Diagnosis: _____

History of Chemical Dependency Treatment ***(date(s), agency(s) and level of care, completed treatment or not):*** _____

_____

History of Mental Health Treatment ***(date(s), agency(s) and level of care, completed treatment or not):***

_____

_____

Medical problems: _____

Current medications: _____

***A consent for the release of confidential information signed by the client is required.**