

**Connect2Recovery (C2R) Referral Form**

Phone: 781-234-1650 Fax: 781-234-1647 Email: Connect2Recovery@riversidecc.org

**Service Requested:**

To evaluate your referral for C2R services, please **complete this form in full** and email to Connect2Recovery@riversidecc.org or fax to 781-234-1647. Please include a signed release if available. Once the information is received, program management will review within 48 business hours.

[ ]  **Community Support Program (CSP)**

[ ] **Community Support Program – Justice Involved (CSP-JI)**

[ ]  **Certified Peer Specialist (CPEER)**

[ ]  **Recovery Coach (RC)**

[ ]  **Recovery Support Navigator (RSN)**

[ ]  **RC & RSN**

**Currently receive services w/ Riverside?** [ ] Yes [ ] No

If yes, indicate which program(s) & location(s):

**Referral Date:**

**Referral Source Name, Contact# & Agency**:

**Personal Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name:  | SSN:  | DOB: | Gender:  |
| Current Address: [ ] Check if homeless | Town/City:  | State:  | Zip: |
| Phone Number: [ ]  Home [ ] Cell | Secondary Contact | Secondary Contact Number: |
| Emergency Contact Name:  | Emergency Contact Relationship:  | Emergency Contact Phone:  |
| Race:  | Ethnicity: | Primary Language:  | Marital Status:  |
| **Eligible Insurance Plans:** [ ] Mass General Brigham [ ] MBHP [ ] WellSense [ ] Fallon [ ] Tufts Public [ ] Commonwealth Care Alliance [ ] Tufts Unify [ ] United Health One Care Plan [ ] Medicaid-Medicare (Cert. Peer, CSP/CSP-JI services only)[ ] Optum Private (plan dependent – RC/RSN services only) | Member ID: |
| Person is aware of C2R referral and would like services? [ ] Yes [ ] No If no, please explain:  |

**Diagnoses (Must include Substance Use Disorder and/or Mental Health diagnosis to process referral):**

|  |  |  |
| --- | --- | --- |
| **Diagnosis** | **ICD-10 Code****(F-Code)** | **Comments** |
|  |  |   |
|  |  |  |
|  |  |  |

**Providers**: *Please include Medical, Psychiatric, Legal, Natural Supports, Other*

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency** | **Role** | **Contact Name** | **Contact Telephone # (s)** |
|  |  |  |  |
|  |  |  |  |

**Referral Information:**

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| **Why does the person want C2R services, and what are they hoping to gain?**  |
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| **What is the person’s current housing situation?**  |
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| --- |
| **Does the individual have any family supports, social supports, or recovery supports? Please describe.** |
| . |

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| **Please list any hospitalizations in the past year including medical, detox, psychiatric admissions, and ED visits:** |
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| **Does the individual have any current or past recovery time? Please describe.**  |
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| **Please describe any current or past legal concerns. (CSP-JI must have criminal justice involvement within the past 12 months)** |
|  |

**GOALS**

*Please check all that apply. Include additional goals if needed.*

[ ]  **Substance Use** [ ]  **Mental Health** [ ]  **Medical**

[ ] Recovery supports or 12-step [ ] Therapy/counseling [ ] Primary Care

[ ] Therapy/counseling [ ] Psychiatrist/medication [ ] Specialists

[ ] IOP/SOAP/day structure [ ] DMH referral [ ] Dental

[ ] MAT (e.g., methadone, suboxone) [ ] Partial/day treatment: [ ] Other:

[ ] Other: [ ] Other:

[ ]  **Housing** [ ]  **Financial** [ ] Legal issues

[ ] Public housing applications [ ] SNAP/EAEDC/TAFDC [ ] Lacks day structure

[ ] Sober/recovery housing [ ] SSI/SSDI [ ] Lacks social/sober supports

[ ] Shelter/safe housing [ ] Employment/Career Center [ ] Lacks transportation to essential medical

[ ] Other: [ ] Mass Rehab and behavioral health appointments

 [ ] Other: [ ] Temporary assistance with transportation

**Is there a history of violence or safety concerns?** [ ] Yes [ ] No If yes,

|  |  |  |
| --- | --- | --- |
| **Violent to:**  | **Most recent date:** | **Information:** |
| [ ]  Self |  |  |
| [ ]  Others  |  |  |

Questions may be directed to Alan Meister, LADC1 by emailing Connect2Recovery@riversidecc.org.