

Partners in Recovery

COMMUNITY BUILDING I II III
2701 North 16th Street, Suite 118
Phoenix, AZ 85006
Phone: (602) 636-4607 Fax: (602) 636-5220

REFERRAL REQUEST FORM

Name: _____ Date of Birth: _____
Social Security Number: _____ Gender: Male Female
Street Address: _____ Describe Housing: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Income/Source: _____
Case Manager: _____ CM Phone #: _____
Clinic: _____ Title 19? Yes No DX Code (see ISP): _____
Specific Goal in ISP that CB will assist with: _____
 Current ISP is attached

Case Manager to complete this section with person receiving services.

I, _____, consent to participate, and give my Case manager permission to release the above information to RIAz Community Building Program for the sole purpose of receiving services from RIAz

Participant's Signature Date

Case Manager's Signature Date

I verify that this person's attendance at RIAz Community Building Program is part of his/her treatment plan as listed in his/her current ISP/ICP.

Case Manager's Signature Date