



California Access to Recovery Effort

(CARE 3)

Revised September 2010

REFERRAL COMPLETION

Client Name: _____ Client ID: _____

Please check one of the following:

The client referenced above is considered appropriate to receive services from our agency and was admitted on _____ (date).

The client referenced above is NOT considered appropriate to receive services from our agency for the following reason(s): _____

Recommended alternative referral(s): _____

The client referenced above is considered appropriate to receive services from our agency but we do not have available capacity at this time.

IF THE CLIENT WAS NOT ADMITTED TO YOUR PROGRAM, CONTACT THE CASE MANAGER LISTED ON THE REFERRAL LETTER IMMEDIATELY SO THE CLIENT CAN BE RE-REFERRED.

Program Name: _____ Provider ID: _____

Program Address: _____

Contact Name: _____ Phone No: _____

Please FAX this completed form to the case manager listed on the referral letter within 3 days of the client presenting to your program.