California Access to Recovery Effort

(CARE)

Form 6

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 has been admitted to the program. Date client was admitted: _________________

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

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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 ASSESSMENT PROVIDER 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 assessment provider listed on the referral letter within 3 days of the client presenting to your program.