THRESHOLDS
SUBSTANCE USE TREATMENT

773-432-6466
www.thresholds.org/substance-use

Internal Referral Form

Date: _____

Please fill in referral information below, and email to Rosa Villanueva at Rosa.Villanueva@Thresholds.org, and CC Ann Brekke at Ann.Brekke@Thresholds.org

Please indicate treatment location:

☐ **South**
12145 S. Western Ave
Blue Island, IL 60406

☐ **West**
3015 W Harrison St
Chicago, IL 60612

Member Information:

Name:	**Preferred Name (with title, if appropriate):**
Smart Care #:	**D.O.B.:**
Phone #:	**Diagnosis (if available):**
Specialized Intake Needs (if applicable):	
Reason(s) for referral:	**Additional Comments:**

Staff & Program Information:

Name:	**Position/Program:**
Phone #:	**Email:**
Team Leader:	**Program Director:**