



Thresholds Substance Use Treatment Referral Form

Date: _____

Please fill in fields below, and attach a completed Release of Information form and current list of medications (if applicable). Fax all referral documentation to Rosa Villanueva at (773) 432-6867 and Amy Abern at (773) 432-6551.

Please indicate treatment location:

South

12145 S Western Ave
Blue Island, IL 60406

West

3015 W Harrison St
Chicago, IL 60612

Referral Information:

Name:	Preferred Name (with title, if appropriate):
Phone Number:	Mailing Address:
List insurance plan and RIN #:	Diagnosis (if available):
Date of Birth:	Social Security Number (SSN):
Reason(s) for referral:	Specialized Intake Needs (if applicable):

Staff Information:

Name:	Company/Agency:
Position/Title:	Program/Department:
Phone Number:	Address of Company/Agency:
Email:	