



## Internal Referral Form

Date: \_\_\_\_\_

Please fill in referral information below, and email to Rosa Villanueva at [rosa.villanueva@thresholds.org](mailto:rosa.villanueva@thresholds.org) and copy (cc) Amy Abern at [amy.abern@thresholds.org](mailto:amy.abern@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 #:	Date of Birth:
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: