

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



SUT West: 773.537.3219

www.thresholds.org/substance-use

## **Thresholds Substance Use Treatment Referral Form**

Please fill in fields below, and attach a completed medications (if applicable). Fax all referral docum		
Please indicate treatment location:		
☐ <b>West</b> 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:		