QUICK RESPONSE TEAM – AGENCY REFERRAL FORM

Phone: 360-801-2020
Fax: 360-874-5595

REFERING AGENCY INFORMATION	
Date/time of referral:	
Agency:	Agency phone number:
Agency Contact(s):	Agency fax number:
Release of information signed: □ YES *(please attach)* □ NO	

CLIENT INFORMATION	
Name:	Date of birth:
Primary number:	Safe to leave message: □ YES □ NO
Secondary number:	Safe to leave message: □ YES □ NO
Primary address:	□ homeless *(please list best area to locate)*
Secondary address:	

Alternative contact name (optional):	Release of information signed: □ YES □ NO
Alternative contact number:	Safe to leave message: □ YES □ NO

Alternative contact name (optional):	Release of information signed: □ YES □ NO
Alternative contact number:	Safe to leave message: □ YES □ NO

REFERRAL REASON(S) (*please check all the apply*)

- ☐ Overdose event follow-up
- ☐ Substance use disorder education
- ☐ Substance use disorder assessment
- ☐ Substance use disorder treatment
- ☐ Behavioral health assessment
- ☐ Peer recovery support
- ☐ Family/caregiver support
- ☐ Naloxone (Narcan) distribution
- ☐ Primary care services *(including infectious disease screening)*
- ☐ Behavioral health services
- ☐ Dental care services
- ☐ Health insurance enrollment
- ☐ Social services coordination *(including food, housing, transportation)*

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Other referral reason(s) or service(s) requested:

****FOR INTERNAL STAFF USE****	
Date/time received:	Receiving staff:
Date/time client contacted:	Contacting staff:
Date/time agency contacted:	Contacting staff:
Primary staff assigned:	