

# REFERRAL FOR RECOVERY PEER SUPPORT SPECIALIST

Please complete the information below and email or fax to the Recovery Support Specialist as soon as peer has chosen to participate in coaching program. The Recovery Support Specialist will email an update upon contact with the peer so that you may update your records.

**Email to: [k.divinity@recoverycouncil.org](mailto:k.divinity@recoverycouncil.org)**

**Fax to: 214-521-7253**

Name of person making referral: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of Peer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Street Address: \_\_\_\_\_

(Street)

(Apt/ PO Box)

(City, State, Zip)

Email; \_\_\_\_\_ State ID#: \_\_\_\_\_

Drug of choice: \_\_\_\_\_

Any Co-occurring: \_\_\_\_\_

Any immediate health concerns: \_\_\_\_\_

Is treatment desired or needed:            Yes            No            Unsure

Most desired immediate goals (I.e. Housing, Employment):

Notes: