THE COUNSELING CENTER
1900 E. 10th STREET
ALAMOGORDO, NEW MEXICO 88310
(575) 488-2500

Substance Use/Misuse Service Referral Form

Name: _____ DOB: _____

Address: _____

Contact Phone Numbers: _____

Referring Agency/Representative: _____

Referring Representative Email/Phone Number: _____

Does this individual have a length of time to complete treatment requirements? _____

If yes, what is the date of completion? _____

Treatment Requests/Requirements:

*Substance Abuse Assessment*_____ *Anger Assessment*_____ *Recovery Coordination* _____

Substance Abuse _____ *Anger Management* _____ *Other*_____

I, _____, UNDERSTAND THAT MY ENDORSEMENT OF THIS FORM CONSTITUTES A RECIPROCATING RELEASE OF INFORMATION. The information to be shared is referral information and compliance/non-compliance notification only.
The following information is subject to disclosure:

- Clinical Assessment
- Recommendations for Services
- Treatment Plan
- Diagnosis/Prognosis
- Attendance
- Monthly Reporting
- Cooperation/progress with treatment
- Discharge

Client Signature: _____ Date: _____

TCC Staff: _____ Date: _____