Wheeler | COMMUNITY | HEALTH | CARE

REACH Program Referral Form

Today's Date: _____

Name of Person completing the referral (if other than client) : _____

Phone_____ Agency Name: _____Email Address: _____

CLIENT INFORMATION

First Name:_____Last Name:_____Date of Birth:___/___/____

Street Address:_____Apt. #: ____ City/State/Zip: _____

Mobile Number: (____)_____- _____ **May we text your mobile phone?** □ Yes □ No

Email Address:_____Race/Ethnicity: _____

Primary language: □ English □ Spanish □ other: _

Reason for Referral:

_____

_____

_____

Number of children: ____ / Ages of children: _____

Is client pregnant? Yes / No (circle one) If pregnant, what is expected due date? _____

Does client have current substance use? Yes / No (circle one)

Is client in current recovery program? Yes / No (circle one)

If yes, what program? _____

Please email completed form to Kelly Bergeron, REACH Program Manager, at kbergeron@wheelerclinic.org

I understand I am being referred to a recovery support program. I understand that REACH is a free and voluntary service for women in recovery who are pregnant and/or parenting young children. I agree to share the above information with the REACH program that I am being referred to. I may choose not to participate in the REACH program at any time. Information about me collected as part of this referral will be kept private and stored in a secure HIPAA compliant database.

*Parent Signature:*_____*Date:* _____