



# California Access to Recovery Effort

(CARE 3)

Revised June 2013

## REFERRAL COMPLETION

Client Name: \_\_\_\_\_ Client ID: \_\_\_\_\_

**Please check one of the following:**

The client referenced above is considered appropriate to receive services from our agency and was admitted on \_\_\_\_\_ (date).

The client referenced above is NOT considered appropriate to receive services from our agency for the following reason(s): \_\_\_\_\_

\_\_\_\_\_

Recommended alternative referral(s): \_\_\_\_\_

The client referenced above is considered appropriate to receive services from our agency but we do not have available capacity at this time.

**IF THE CLIENT WAS NOT ADMITTED TO YOUR PROGRAM, CONTACT THE CASE MANAGER LISTED ON THE REFERRAL LETTER IMMEDIATELY SO THE CLIENT CAN BE RE-REFERRED.**

Program Name: \_\_\_\_\_ Provider ID: \_\_\_\_\_

Program Address: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Please FAX this completed form to the case manager listed on the referral letter within 3 days of the client presenting to your program.

**CARE CALL CENTER | 1-866-350-8773 | OFFICE HOURS: MON - FRI, 8 AM TO 5 PM**