Referral for ADOLESCENT Addiction Services
To Barrington Youth and Family Services

REFERRAL SOURCE INFORMATION **DATE OF REFERRAL**: _____

Referred by (contact person): _____

Agency/School, Town: _____

Relationship to the client AND/OR Role at School: _____

Your phone numbers: (____) _____ (____) _____
Work Cell (if appropriate)

Fax number: (____) _____

Would you like to be kept informed about disposition of referral? ☐ Phone ☐ Email ☐ Summary report ☐ Not necessary

Any additional agency members need to be alerted? If so, whom and describe benefit to treatment: _____

_____

_____

Has a Release of Information been signed on your end? ☐ Yes ☐ No

CLIENT'S INFORMATION:

Client Name: _____ DOB: _____ Grade: ____ Age: ____

School: _____ Town, School: _____

Home Address: _____

_____ _____ _____
City State Zipcode

Home Ph:(___) _____ Client Cell Ph: (___) _____ Parent/Guardian Cell Ph: (___) _____

REASON FOR REFERRAL:

What addiction services are being sought?

☐ Individual therapy ☐ Intensive Outpatient Group ☐ DUI Evaluation

☐ Early Intervention Group ☐ After Care Program ☐ DUI Risk Education

_____

_____

_____

Disposition of referral (BYFS Office use only):

☐ Assessment scheduled ☐ Early Intervention Group ☐ DUI Evaluation

☐ Referral to higher level of care (describe/identify below) ☐ Intensive Outpatient Group ☐ DUI Risk Education

☐ After Care Program ☐ Consult with Medical Director

☐ Individual Therapy ☐ Other: Describe below

_____

_____

For non-emergency referrals, fax this form to (847) 381-9297; email: info@BarringtonBYFS.org

Barrington Youth and Family Services
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Barrington IL 60010
O: (847) 381-0345 F: (847)381-9297