Referral Form

Adolescent Substance Abuse Treatment Program

601 South Black Horse Pike Williamstown, NJ 08094

594 Benson Street Camden, NJ 08103

Phone: 1.877.9.ACCESS Fax: 856.728.1407 Email: adolescentsubstanceabuse@centerffs.org

Date ______________________

Client: ______________________________________ Date of Birth: ________________________

Parent/Guardian: _____________________________ Phone Number: ______________________

Address: ____

Date the client was provided the referral: __________________________________

Reason(s) for referral ____

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Referral Source: _____________________________________

Contact Person: _______________________________ Phone Number: ________________________

Email Address: _______________________________ Fax Number: ___________________________

Address: ____

The client has signed a release of information Yes ______ No______

- If a release of information is completed please send with the referral form.

Additional comments____

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This form is available for download at centerffs.org.

Last revised 7/11/2014