REFERRAL FORM
SUPPORT TEAM FOR ADDICTION RECOVERY (STAR)
Camden, Gloucester ,Cape May, and Salem Counties
EMAIL: ACCESS@CENTERFFS.ORG

Name: _____ Date: _____

Address: _____

City: _____

County: Camden ☐, Gloucester ☐, Cape May ☐, Salem ☐ Zip Code: _____

SS#:_____-_____-_____ DOB: _____

Phone #: _____ Email: _____

Referred by: _____

Drug(s) of Choice: (Eligibility Requirement)

Stimulants: Methamphetamines ☐ Cocaine, ☐ Crack, ☐ other _____

Opioids: Heroin ☐Fentanyl ☐ Oxycodone ☐ Methadone ☐ Suboxone ☐ Other _____

_____ _____

STAR Staff Assigned Date:

_____ _____

Supervisor Signature Date/Time:

Revised 7/26 by Andora Hightower, Director of Community Based Recovery Programs