Client Referral Form

Peer Outreach Recovery & ReEntry Services

Reaching back. Pulling forward. Together.

Please complete all applicable sections. A PORRS team member will contact the referral source within two business days. Email the completed form to Admin@peeroutreachaz.org or call 602-816-1493.

1. Referral Source

Referring Person (Name):

Organization / Agency:

Title / Role: Phone: Email:

Referral source type (check all that apply):

☐ VA / Veteran Service ☐ Tribal Health / IHS ☐ Court / Probation / Parole

☐ Hospital / Clinic ☐ Behavioral Health Provider ☐ Self / Family ☐ Other:

2. Client Information

Last Name: First Name: Date of Birth:

Phone: Alternate Contact (name / phone): Best Way to Reach:

Current Address / Location (if homeless, note location or shelter):

3. Client Population

(check all that apply)

☐ Veteran / Active Military ☐ American Indian / Alaska Native

☐ Justice-Involved (probation, parole, ReEntry, diversion) ☐ Homeless or at risk of homelessness

☐ Substance use concern ☐ Mental health concern

4. Insurance / Coverage

AHCCCS ID (if known): AHCCCS Plan (AIHP / ACC plan name):

TriWest / Other:

☐ AHCCCS AIHP ☐ AHCCCS ACC ☐ TriWest / VA ☐ Commercial / ACA ☐ Uninsured / Unknown

5. Reason for Referral

(check primary needs)

☐ Peer Recovery Support ☐ Recovery Coaching ☐ Community Health Worker / Outreach

☐ Health System Navigation ☐ ReEntry Navigation ☐ Housing Linkage

☐ Benefits / ID / Documents ☐ Treatment / MAT Linkage ☐ Family / System Navigation

Brief description of client situation and goals (what does the client need help with?):

6. Safety & Risk Screening

Please flag any active safety concerns so PORRS can respond appropriately. Peer services are not crisis services.

☐ Current suicidal ideation ☐ Current homicidal ideation

☐ Active domestic violence ☐ Acute medical concern

☐ No active safety concerns at this time

7. Consent & Release

By submitting this referral, the referring party confirms that the client (or legal guardian) has consented to: (1) PORRS contacting the client to offer services, and (2) two-way information sharing between the referring agency and PORRS as needed for service delivery and health system navigation. A signed Release of Information will be obtained at intake when applicable.

☐ I confirm that client consent has been obtained as described above.

Referring Person — Signature (typed name acceptable): _____ Date: _____

For PORRS Internal Use

Received by: _____ Date received: _____ Assigned to: _____

Disposition / Notes: _____