KAREN RECOVERY PROGRAM
REFERRAL FORM

A project of HealthEast &
Karen Chemical Dependency Collaboration
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Phone: 651-326-5743 Fax: 651-326-8288 (Tonya Horn)

Referral From:

Name: _____Phone: _____

Agency/Role: _____

Reason for Referral: _____

_____

_____

Client Information:

Name: _____DOB: _____

Address: _____

Phone: _____ Does this patient have an insurance provider? □ No □ Yes

Insurance Provider:_____

Member #: _____Group #: _____

Does this patient require an interpreter? □ No □ Yes - Language: _____

FAX COMPLETED FORMS TO: 651-326-8288 ATTN: Tonya Horn