Manifest Wellness

Substance Abuse Treatment Referral

608-291-3676

info@manifestwellnesswis.com

Full Name:

Date of Birth:

Gender Identity:

Preferred Pronouns

Address:

Phone Number:

Email:

Telehealth or in person?

Preference of location of services?

Emergency Contact:

Emergency Contact Phone:

Referring Agency/Organization:

Referrer's Name:

Referrer's Phone:

Referrer's Email:

Please provide a brief description of the client's situation and the reason for the referral:

Please provide a brief overview of the client's history of substance use, including the duration, frequency, and substances used:

Does the client have a preferred drug of choice? If yes, please specify:

Please include any additional information or specific requirements that the counselor/service provider should be aware of:

Consent and Authorization:

By signing below, I confirm that I have obtained consent from the client to refer them for substance abuse counseling services. I understand that the information provided will be used solely for the purpose of facilitating the referral process.

Client Signature: _____

Date: _____

● t: 608-291-3676
● f: 608-716-3156

Manifest Wellness, LLC
P.O. Box 930155
Verona, WI 53593

www.manifestwellnesswis.com