



Highland Recovery Center Referral Form

Men's Residential Treatment

*Note Highland Rivers Behavioral Health [636 Eligibility for Services Policy](#) requires face to face assessment for determining individual level of care needs.

Name: _____ Date of Birth: _____

Physical Address: _____

Mailing Address: _____

Primary Phone Number: (_____) _____ - _____

Secondary Phone Number: (_____) _____ - _____

How were you referred you to the Highland Recovery Center?

Marital Status: Single Married Divorced Partnered

Employment Status: _____

Substance Use History (please check all that apply):

Alcohol Marijuana Methamphetamine Heroin Cocaine/Crack Hallucinogenic
 Benzodiazepines Opiates Other _____ IV Drug Use

Please indicate last date of use and amount used for above identified substances:

Significant Medical History:

Seizure Disorder Hepatitis C Tuberculosis Diabetes Traumatic Brain Injury (TBI)
 Other conditions that may require 24/7 medical care or observation.

***Note:** These issues do not mean you will be disqualified from entrance into the program.

Please note any other significant medical conditions:

Nicotine use: Non-user Periodic user Daily user

Current Medication(s):



History of Treatment for Mental Health/Substance Use and any know Diagnosis:

- Inpatient Detoxification Inpatient Mental Health Outpatient Substance Use
 Outpatient Mental Health Residential Substance Use

Please explain above identified treatment (Where and When):

Current/Pending/Past legal History (*this would include current probation*) (If Applicable):

Probation/Parole Officer Contact information (If Applicable):

Name: _____ County: _____

Phone Number: () _____ - _____ Fax Number: () _____ - _____

Have you participated in a Treatment Court program? Yes No

If yes, please explain the outcome or current participation:

Insurance (If uninsured please note): _____

Primary Care Physician Contact Information:

Name: _____ Phone Number: () _____ - _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

Phone Number: () _____ - _____

Attorney Contact Information (If Applicable):

Name: _____ Law Firm: _____

Phone Number: () _____ Fax Number: () _____



By signing below, you attest that the information you have provided in this referral form is accurate to the best of your knowledge. Your signature below and on the attached Releases of Information (ROI), acknowledges that the Highland Recovery Center (HRC) may contact you, your referral source, and any relevant legal/treatment entities involved in your admission process, for the purpose obtaining more information pertaining to your current status and eligibility for admission, as further delineated by the accompanying ROI. Furthermore, this will serve to relay any relevant information regarding the nature of the program, and/or your date of admission should you be placed on the program's waiting list.

Referrals are staffed weekly with interdisciplinary team, including HRC attending physician.

Incomplete referral forms will result in delay of interdisciplinary team review.

Printed Full Name: _____

Signature: _____ Date: _____

Attached to this referral form you will find two blank Releases of Information (ROI) for Highland Rivers Behavioral Health to communicate with any relevant parties involved in your possible admission and treatment. Releases of Information may be rescinded at any time by the applicant.

Please return this completed referral form to The Highland Recovery Center via mail, email, or fax to the contact(s) listed below:

Address: Highland Recovery Center (HRC)

Attn: Randall Wilson

323 Roland Road

Jasper, GA 30143

Fax: 706-253-1113

Email: randallwilson@highlandrivers.org

For further information please contact:

Randall Wilson ICADC, CAD1, CAMS II, CPS

Highland Recovery Center (HRC) Residential Program Manager

Highland Rivers Behavioral Health

Phone: 706-253-1169 Ext: 5302

Work cell: 678-908-7472