PROJECT RESTORE
A PROGRAM FOR YOUNG ADULTS

A PROGRAM OF:
EMPOWER Tehama

INITIAL ASSESSMENT REFERRAL FORM

Date: _____

Referring Agency: _____ Referring Person: _____

Phone #: _____ Fax#: _____

Person Being Referred:

Name: _____ DOB: _____ Age: _____

Address: _____ Phone:_____

Reason for Referral: _____

_____

_____

☐ Client has been directed to contact your program/agency by (date): _____

☐ Release of Information attached *(Required for Providing Referral Outcome)*

FAX COMPLETED REFERRAL TO EMPOWER TEHAMA AT 530-727-9425

INITIAL ASSESSMENT REFERRAL OUTCOME

Date: _____ To:_____

From: **Empower Tehama** Phone: **530-727-9423** Fax: **530-727-9425**

The following is the status of your referral:

- ❑ Client No Showed as directed above
- ❑ Client assessed and was not eligible for services/did not meet medical necessity.
  - ❑ Client referred to more appropriate services at: _____
- ❑ Client showed and is scheduled for an assessment on (date/time): _____
- ❑ Client showed and was not interested in services.
- ❑ Client showed, was assessed and scheduled to begin services on (date): _____
- ❑ Client referred to PROJECT RESTORE component(s):
  - ❑ TCHSA Substance Use Recovery on (date):_____
  - ❑ TCHSA Behavioral Health on (date): _____
  - ❑ Empower Tehama Anger Management on (date): _____
  - ❑ Other: _____ on (date): _____

Comments:_____

_____

Empower Tehama staff completing Initial Assessment Referral Outcome:

Name: _____ Title: _____