Recovery Coaching Referral Form

Recoveree Information

Recoveree Name **Date**

Address

Contact Information [Phone or email]

DOB **Gender Identity**

Insurance Plan & ID

DSM-5/ICD10 Codes **Diagnosed by (name of provider)**

➔ **Does this person have reentry challenges – returning from jail/prison?** ☐ **YES** ☐ **NO**

Referral Information

Person making referral [Name]

Contact Information [Phone or email]

Please fax insurance card/information with completed form and ROI to:
Attn: Richard Hollett
Fax: (978)528-4788

Riverbend

Formerly known as Lowell House, Inc.