



SAFE HARBOR

RECOVERY CENTER

Safe Harbor Recovery Center Referral Form

Name of client: _____ Date of Birth: _____

Phone Number: _____ Last 4 of Social Security: _____

Address: _____

Drug of Use: _____ Last Date of Use: _____

Name of Organization Referring: _____

Commercial Insurance: ☐

Medicaid Insurance: ☐

Other: ☐

Member ID or Plan: _____

Additional Information: _____

Date Referral Submitted: _____