Recovery Residence Referral Record

Date of Referral	Client Name	Copy of Referral (Sent and/or Received) YES or NO	Received From (include name/location)	Referred To (include name/location)	Provider Staff Signature

Please check one of the following:

☐ I attest that the information above is accurate and complete.

☐ I attest that __ (agency name) _____ has not received patients from or referred patients to any recovery residence.

Please Note: If it is determined that the provider has received patients from or referred patients to any recovery residence, they will be subject to the fine as outlined in s.397. 4104, F.S.

Program Director Signature: _____ **Date:** _____

July 1, 2022 (Revised 8/23/22)

Instructions:

1. **Date:** The date in which the client was referred to or received from
2. **Client:** Full client name (First/Last)
3. **Copy of Referral:** Did you send a referral or receive a referral? Ensure that a copy is kept in the client record.
4. **Received From:** List the name/location of the provider you received client from.
5. **Received To:** List the name/location of the provider you referred client to.
6. **Non-Certified Recovery Residence:** If a client was received from a non-certified recovery residence, enter the name/location of that facility.
7. **Provider Staff Signature:** Signature of the provider staff person who received or referred a client.

NOTE: This log must be kept in a Residence Recovery Log Binder and will be reviewed by the Department at any time.