THRESHOLDS
SUBSTANCE USE TREATMENT

SUT West: 773.537.3219

www.thresholds.org/substance-use

Thresholds Substance Use Treatment Referral Form

Date: _____

Please fill in fields below, and attach a completed Release of Information form and current list of medications (if applicable). Fax all referral documentation to Rosa Villanueva at (773) 432-6551.

Please indicate treatment location:

☐ **West**
3015 W Harrison St
Chicago, IL 60612

Referral Information:

Name:	**Preferred Name (with title, if appropriate):**
Phone Number:	**Mailing Address:**
List insurance plan and RIN #:	**Diagnosis (if available):**
Date of Birth:	**Social Security Number (SSN):**
Reason(s) for referral:	**Specialized Intake Needs (if applicable):**

Staff Information:

Name:	**Company/Agency:**
Position/Title:	**Program/Department:**
Phone Number:	**Address of Company/Agency:**
Email:	