*REQUIRED

Zufall Health Center

Date: __ __-__ __-__ __

M-Wrap & Somerset Maternal Recovery Support Program
Initial Referral Form

(Secure Fax Number: **973-328-6817 attn: Nettie Mendez**)
or call 862-219-0262 for SMRS and 862-432-5542 for M-Wrap

Participant Information

_____ _____ __ __-__ __-__ __

*Last Name * First Name *Date of Birth

_____ _____

* Street Address * City

__ __ __ __ __ _____

*Zip code *County
(Somerset – SMRS program)
(Morris, Sussex, Warren – M-Wrap, pregnant only)

Primary Language: ___ English
___ Spanish
____ Other: _____

Participant Contact Information

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
*Primary Phone

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Alternate Phone

_____
Email Address

*Preferred Contact Method *(choose one)*
__ Primary Phone
__ Alternate Phone
__ Text

*At which number can we text you?
___ Primary ___ Alternate ___ None

*Pregnant?
___ Yes ___ No

Due Date:
___ ___ - ___ ___ - ___ ___

In Prenatal Care?
___ Yes ___ No

Date of Most Recent Substance Use? _____

Referral Agency Information:

_____ _____
*Agency Name *Address/Location

_____ _____
*Name of Person Making Referral *Phone and extension number

_____
Email Address

_____
Additional Comments:

*Participant Consent:

I agree to provide the information above and to have it forwarded as a referral to Zufall Health Center's Recovery Support Programs. I agree to be contacted and for staff to follow-up with me or the agency to which I was referred to support my care. I authorize the referral agency to release necessary information to Zufall Health (and vice-versa) to assist with the referral process.

Signature of Participant (18 yrs old and older) or *(Referring Person if Obtained Verbal Consent from the Participant)*

Sign: _____ *Print:* _____ *Date*:_____