



Referral Form to ATR

This form is to be completed by the referral agency; not the interested participants themselves.

- *Treatment providers*: please attach a recently completed bio-psych-social assessment along with this form
- *Non-treatment providers*: please answer the questions on page 2 and send along with this form

Name of Participant _____ Date of Birth _____

Participant Social Security Number _____ Participant Phone # _____

Must meet all of the following criteria to be eligible for ATR:

1. First time participating in ATR

**If the person has ever been through ATR in the past, they are NOT eligible to receive ATR services again.

2. Risk of developing an opioid use disorder, has an opioid use disorder, or has a history of overdose

3. Motivated to work on their recovery

4. In the early stages of recovery (around 2 years or less)

5. Resides in Greater Boston, Greater Springfield, New Bedford or Worcester, and plans to be there for the next 6 months

6. Is 18 years old or older

7. Connected with a case manager (or some other staff person) in the recovery community.
Preference is given to authorized referral portals

Please list this person's contact information below:

Case Manager/Staff Name:	From what organization?
Phone:	Email:

8. Identifies with at least one of the following target groups:

- a. Recently released from incarceration
- b. Currently a participant in a MA drug court
- c. Served in the US Military
- d. Pregnant, post-partum or parenting woman with children under 18 years old living in the home
- e. Part of a substance use treatment program (i.e. long-term residential treatment, medication assisted treatment program)

Referring Provider Name _____ Date _____

Referral Contact Information _____



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These questions should be completed by referring providers who do not have a bio-psych-social assessment to send with the referral. The purpose is to provide some additional background information on the individual that is being referred to the ATR program.

Participant's name, date of birth, and phone number:

How long has this person been in recovery from drugs or alcohol?

What is their substance use disorder/substances used?

List community supports this person is using (please include agency name, contact person and phone number):

How is this person doing in their recovery? What is their level of motivation to maintain recovery?

What does the person hope to accomplish from ATR? What ATR services would benefit this individual?