Stonehenge
Therapeutic Community

Support. Hope. Thrive.

SUPPORTIVE ADDICTION AND MENTAL HEALTH HOUSING

Transitional Housing Community Partner Referral

Client Name:		Primary Contact information (phone/email):	
Best way to reach client:			
Date of Birth:			
Name and contact info of referring worker:			
Community service provider involvement	List all providers involved and their role: 1. 2. 3.		

Is this client interested in abstinence based Transitional Housing and the requirements of meeting regularly with support staff?

- ☐ Yes
- ☐ No
- ☐ Unknown

Current Housing Situation: ☐ Homeless ☐ Precariously Housed ☐ Housed ☐ Incarcerated	Please describe:
Mental Health and Justice involvement: Y / N	Please describe:
Substance use treatment history: *Must be within the last 12 months*	Please describe:
Funding source:	Please describe:

SAMH USE ONLY: SCREENING OUTCOME

- ☐ Eligible
- ☐ Ineligible
  Please specify: