



Referral for Services Outpatient Substance Treatment

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____
Email address: _____ *(required for the scheduling processing)*
Social Security #: _____ Gender: Male Female
Date of Birth: _____ Race: _____
Veteran: Yes No
Pregnant: Yes No N/A
Injecting Drug User: Yes No
Has Medicaid: Yes No #: _____
Has Private Insurance: Yes No Name/ID #: _____
Has an open CPS case: Yes No
Is on Probation/Parole: Yes No

Referral Information:

Agency: _____ Person Making Referral: _____
Contact Number: _____ Email: _____
Comments: (Explain the basis for this referral)

STAR Council has offices in the following locations. Each referral will be reviewed to determine the best location for services.

Stephenville, TX Cleburne, TX Decatur, TX

Please return the completed referral sheet with any accompanying documentation to the referral department by fax or email, see below. We thank you for your time and assistance, it is appreciated. If you have questions or concerns, please do not hesitate to contact us at 800.375.1395.

Preferred method of contact:
referrals@starcouncil.org

Fax:
(254) 965-7416
Attn: Referrals