LMAS DISTRICT HEALTH DEPARTMENT

Harm Reduction and/or Peer Recovery Coaching Referral Form

Date of Referral: _____

Referral Contact Organization: _____ **Contact Number**: _____

Participant Information (client may request to have anonymous referral or use an alias)

Client First Name: _____ Last Name: _____

Address: _____ State _____ Zip _____

Preferred Phone Number: _____Alternate Number:_____

Reason for Referral:

☐ Harm Reduction

- ☐ Syringe Exchange ☐ Naloxone training and distribution
- ☐ Safer sex education ☐ Rapid HIV and/or Hepatitis C testing
- ☐ Hepatitis A Hepatitis B, Tdap, Covid vaccine
- ☐ Other_____

☐ Peer Recovery Coaching

Social Determinants of Health Needs

☐ Housing	☐ Healthcare	☐ Food	☐ Childcare
☐ Transportation	☐ Utilities (electric, gas, Water, Oil)		☐ Employment
☐ Education	☐ Finances	☐ Personal Safety	

Any preferences or additional needs for ensuring an effective, safe, mutually respectful working relationship:

_____

_____

_____

Please Fax Referral Form to: (906) 387-2224 **Peer/Harm Reduction Contact**: (906) 322-4444

LMAS Staff ONLY

Referral Contact: _____, _____, _____Enrolled Date: _____Entered Into Database _____

Staff Initials: _____ Date _____ Time _____