



Sister League

OF SAN DIEGO

REFERRAL FOR RESIDENCY

Instructions for Referral

Please fill out the information below and have the potential resident sign the release of information so medical records can be obtained. Send completed referral intake form via email to Info@SisterLeaguesd.org or fax (619) 269-1098. If you have any questions, please call (619) 692-1485. **PLEASE INCLUDE A SIGNED COPY OF RELEASE OF INFORMATION.**

Referring Agency: _____

Referring Case Manager: _____

Case Manager Contact Number: _____

PERSONAL INFORMATION

Name _____ Phone _____

Address _____ City _____ State ____ Zip _____

Source of Income/Amount: _____

REASON FOR REFERRAL

Current Housing Situation: _____

Mental Illness Diagnosis: _____

Last date of drug use (what was used, including marijuana): _____

A brief description of needs: _____

THIS SECTION IS FOR BSL USE ONLY

	Date	Initials
Referral Received		
First Client Contact		
Assessment Date Confirmed		
ROI Sent		
Medical Records Received		
Assessment Date		

Accepted :

YES

NO

If not accepted, provide reason: _____
