

Recovery Coaching Referral Form



LOWELL HOUSE ADDICTION
TREATMENT *AND* RECOVERY

Recoveree Information

Recoveree Name

Date

Address

Contact Information [Phone or email]

DOB

Gender Identity

Insurance Plan & ID

DSM-5/ICD10 Codes

Diagnosed by (name of provider)

➔ Does this person have reentry challenges – returning from jail/prison? YES NO

Referral Information

Person making referral [Name]

Contact Information [Phone or email]

Please fax insurance card/information with completed form and ROI to:

Attn: Richard Hollett

Fax: (978)528-4788

For additional information please contact Richard Hollett.

Email: Rhollett@lowellhouseinc.org

Phone: (978)735-3734