Gateway Alcohol & Drug Treatment Centers
Referral Form

Gateway Foundation | Alcohol & Drug Treatment Centers

PATIENT/CLIENT INFORMATION

Patient Name______________________________ Birth date / /

Parent(s)/Guardian Name(s), *if a minor*______________________________

Home address______________________________

Phone Number______________ Is it ok to leave a message at this number? (circle one) Yes No

Insurance Private Pay Unfunded Medicaid

REFERRAL SOURCE INFORMATION

First & Last Name______________________Organization______________________

Address______________________ City, State ______________________

Phone ______________________ Fax______________________

Reason for referral______________________________

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TREATMENT CENTER INFORMATION

- All programs start with a comprehensive assessment to determine appropriate level of care.
- Adults and Adolescents
- Outpatient and Residential

NORTHERN IL	CENTRAL IL	ST. LOUIS METRO EAST AND SOUTHERN IL
Aurora: 400 Mercy Ln. Chicago: • 444 N. Orleans • 3828 W. Taylor St. Lake Villa: 25480 W. Cedarcrest Ln	Pekin: 11 South Capital Springfield: 2200 Lake Victoria Dr.	Carbondale: 1080 E. Park St. Caseyville: 600 W. Lincoln Swansea: 1 Bronze Pointe

Consent to Contact

Referral Signature______________ ______________________ Date: ______________

Patient Signature______________________________

Gateway Alcohol & Drug Treatment is a behavioral health care organization that is bound by strict state and federal privacy and confidentiality regulations. **Please fax this form. Do not email.**

Fax form to 888-975-0939

Questions? Call: 877-505-4673.
For emergency situations, please go to your local emergency department or call 911.

This form is available at RecoverGateway.org