Recovery Services
3727 W. 6th Street, Suite 411
Los Angeles, CA 90020

Tel: (213) 365-7400
Fax: (213) 263-9622

KYCC Recovery Services Referral Form

Demographic information		
Date:	**Phone Number:**	
Client Name:	**Okay to leave voicemail?** ☐ Yes ☐ No	
Race/Ethnicity:	**Preferred Language:**	
DOB:	**Age:**	**Gender:**
Address:	**School Name:**	
Parent/Caregiver Name (If Minor):	**Preferred Language:**	
Parent/Caregiver Phone Number:	**Okay to leave voicemail?** ☐ Yes ☐ No	
Insurance Type: ☐ None ☐ Medi-Cal ☐ My Health LA ☐ Other: **Insurance Number:**	**Issue Date:**	
Living Arrangement: ☐ Homeless ☐ Living with family ☐ Living in foster care ☐ Other (specify):		
Referred By: **Agency:**	**Phone Number:**	

Brief explanation of why client is currently seeking treatment:

Has your client received any treatment for alcohol, marijuana or other drugs in the past? ☐ Yes ☐ No

Has your client used the following in the last 30 days?

☐ Alcohol ☐ Marijuana ☐ Cocaine/Crack ☐ Heroin ☐ Inhalants

☐ Methamphetamine ☐ Prescription Drugs ☐ Other ________________________

This Section For Internal Use Only	
Review Date:	**Reviewed By:**
Screening/Triage Assigned to:	
Comments:	