S.T.A.R. Referral Form

Date of Referral: _____ Referred by: Clinic ☐ Doctor ☐ Self ☐ Family/ Friend ☐
Behavioral Health Provider ☐ Other ☐

Member Information

Member Name: _____ Date of Birth: _____

AHCCCS ID#: _____ Diagnosis Code: _____ Title XIX ☐ Non-Title XIX ☐

Physical Address: _____

Phone #: _____ Primary Language: _____

Relevant medical conditions or allergy risks: _____

Does member have any behaviors or needs that require additional attention from S.T.A.R. staff: _____

_____

Is the members an immediate or imminent danger to self or others? Yes ☐ No ☐

Cross System Involvement: DDD ☐ Probation ☐

Please list any chronic physical health issues the member is currently being seen for: _____

_____

Doctor's Name: _____ Doctor's Phone #: _____

Guardian's Information (if applicable)

Guardian's Name: _____ Guardian's Relationship to member: _____

Guardian's Phone# (if different from above): _____ Best time to contact: _____

Assigned Clinic Information

Assigned Clinic Agency: _____

Case Manager Name: _____ Clinic Phone #: _____

Case Manager Email Address: _____

Areas of interest to the member:

- ☐ Peer Support
- ☐ Recovery Focused Groups
- ☐ Discharge Care Coordination
- ☐ Individual Counseling
- ☐ Group Counseling
- ☐ Opioid Support Groups
- ☐ Independent Living Skills
- ☐ Job Skills
- ☐ Young Adult Program (Ages 18-25)
- ☐ Transportation
- ☐ Health, Wellness, and Exercise
- ☐ NTXIX Chronic Medical Services

Location of interest to member:

- ☐ S.T.A.R. Central (Phoenix)
- ☐ S.T.A.R. East (Mesa)
- ☐ S.T.A.R. West (Avondale)