



FAMILY GROUP DECISION MAKING OUD/POLY REFERRAL FORM

Referral Source:		Date of Referral:	
Referral Name:		Date to Provider Agency: <input type="checkbox"/> FSNWPA	
Referral Phone Number:		<u>Type of Service Caseworker assesses to be most appropriate for the Family's needs at this time:</u>	
Referral Email:		<input type="checkbox"/> FGDM Conference	
Send Referrals to: Program Supervisor Tim Keibler timk@fsnwpa.org 814-866-4650		<u>Type of Plan Requested</u>	
		<input type="checkbox"/> Poly-use Disorder	
		<input type="checkbox"/> Opioid Use Disorder	
Client(s) Name:		Social Security # (Optional):	
Client(s) Address:			
Client(s) Phone:		Client(s) Email:	
Reason for Referral:			
Other Household Members:			
Name	Phone Number	Age	Relationship to Family
Current Services:			
Bottom-Line Concern:			
What is the hope for the client(s)?			

Main Office
 5100 Peach Street
 Erie, PA 16509

Downtown Erie Office
 240 West 11th Street
 Fourth Floor
 Erie, PA 16501

Crawford County Office
 18360 Technology Drive
 Suite 200
 Meadville, PA 16335

Mercer County Office
 7 West State Street
 Suite 208
 Sharon, PA 16146