

Waitlist for Date _____

Entered in WTIS by _____

First Name _____ Last Name _____ Gender _____ D.O.B _____
SSN _____ Class Member? YES NO Pregnant? YES NO Injection Drug User? YES NO

REHABILITATION/RESIDENTIAL

<input type="checkbox"/> Hospital (Other than Detoxification)	<input type="checkbox"/> Extended Care	<input type="checkbox"/> Adolescent Res. Rehab. Transitional
<input type="checkbox"/> Short Term (30 days or less)	<input type="checkbox"/> Halfway House	<input type="checkbox"/> Consumer Run Residence

AMBULATORY

<input type="checkbox"/> Non-Intensive Outpatient	<input type="checkbox"/> Adolescent Outpatient	<input type="checkbox"/> Opioid Replacement Therapy
<input type="checkbox"/> Intensive Outpatient	<input type="checkbox"/> Adolescent Intensive Outpatient	
<input type="checkbox"/> Detoxification		

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