



# Referral Form

Date of Referral \_\_\_\_\_

**Please Include the Following Requirements:**

1. Referral Page
2. Substance Abuse Assessment – Most Recent
3. Contact Phone Number
4. Current Valid Driver's License/State ID – Send Copy

Full Name: \_\_\_\_\_  
*Last First M.I. Age Date of Birth*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*

County of Legal Residence: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Race: \_\_\_\_\_ Hispanic:  YES  NO Veteran:  YES  NO # of Dependents: \_\_\_\_\_

Education Level: \_\_\_\_\_ Annual Gross Income: \_\_\_\_\_ Income Source: \_\_\_\_\_

SSI/SSDI Eligible:  YES  NO Insurance:  YES  NO EPC or MHB:  YES  NO Suicide Attempts in Last 30 Days:  YES  NO

Prior to Treatment Living Arrangements:  ALONE  W/RELATIVES  W/NON-RELATED Type of Residence: \_\_\_\_\_

Legal Status: \_\_\_\_\_ # of Arrests in Last 6 Months: \_\_\_\_\_ IV Drug User:  YES  NO

Mental Health Diagnosis (Specify): \_\_\_\_\_

Medications: \_\_\_\_\_

Dr.'s Appointment or Refill Instructions: \_\_\_\_\_

	1 <sup>st</sup> Drug of Choice		2 <sup>nd</sup> Drug of Choice		3 <sup>rd</sup> Drug of Choice	
Name of Drug						
Age of 1 <sup>st</sup> Use/Date Last Use						
Use in Past Month/How Often?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Volume/Per Day, Week, or Month						
Route (Oral/Nasal/Smoke/IV)						

# of Prior Treatment Episodes: \_\_\_\_\_ Admission Date: \_\_\_\_\_ Expected Discharge Date: \_\_\_\_\_

Referred By (Counselor): \_\_\_\_\_

Referral Taken By: \_\_\_\_\_