**Referral Form**

Client Name: Date:

Address: [ ] \*Mark if HOMELESS

Phone: DOB: Language:

Sex: M F Marital Status: Race:

SS#:

Substance of Abuse (list all current):

Primary Substance Used: Last Use: How Used:

Medical Concerns:

Mental/Behavioral Health Diagnosis:

**TREATMENT INFO:**

Level of Care and Provider: Admit Date:

Probation/Parole Officer: YES NO P.O. Name:

Pending Legal Charges? YES NO

Does client have transportation/access to transportation? YES NO

Referring Person’s Name/Facility/Contact #:

Relevant comments (specific needs, concerns, etc.):