



**Substance Use Disorder Treatment Referral (Ambulatory)**

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_  Unhoused Length at Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Social Security #: \_\_\_\_\_ U.S. Citizen:  Yes  No

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Gender:  Male  Female  Non-Binary

Occupation: \_\_\_\_\_ Active Employment:  Yes  No  Retired  Unable to Work (Active SSD)

Health Insurance (Active):  No  Yes If yes, name of health plan: \_\_\_\_\_

Do you have a history of a sex offense?  No  Yes Do you have a history of fire setting?  Yes  No

Are you able to speak and understand the English language to participate in treatment?  Yes  No

Do you require any accommodations to engage in treatment?  No  Yes Specify: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical & Psychiatric Needs**

Do you experience any involuntary bladder leakage or other incontinence?  No  Yes

Please identify all existing known psychiatric diagnosis: \_\_\_\_\_

Have you ever acted on thoughts about hurting yourself or others before?  No  Yes If yes, please clarify including last occurrence: \_\_\_\_\_

Have you ever attempted suicide?  No  Yes If yes, date of last attempt: \_\_\_\_\_

Have you ever engaged in acts of self-harm?  No  Yes If yes, date of last attempt: \_\_\_\_\_

Have you ever experienced hallucinations?  Auditory \_\_\_\_\_  Visual \_\_\_\_\_  No

Medications for Opioid Use Disorder:  Acamprosate  Disulfiram  Naltrexone  Topiramate  Naltrexone  Buprenorphine  Methadone

None Current Dose: \_\_\_\_\_ OTP Clinic: \_\_\_\_\_

Are you currently prescribed any medications?  No  Yes If yes, please specify below:

Current Prescriber's Name: \_\_\_\_\_ Phone: \_\_\_\_\_



Medication	Dose (if known)	Frequency	Taken As Directed
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More

Substance Use History					
Substance	Date of Last Use	Age of First Use	Frequency	Usual Amount Per Day	Route of Use
Alcohol					<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Nasal <input type="checkbox"/> Inject
Sedative-hypnotics/anxiolytics (i.e. alprazolam, other benzos):					<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Nasal <input type="checkbox"/> Inject
Opioids:					<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Nasal <input type="checkbox"/> Inject
Stimulants (i.e. meth, cocaine):					<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Nasal <input type="checkbox"/> Inject
Cannabis:					<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Nasal <input type="checkbox"/> Inject
Hallucinogens:					<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Nasal <input type="checkbox"/> Inject
Inhalants:					<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Nasal <input type="checkbox"/> Inject
Tobacco/Nicotine:					<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Nasal <input type="checkbox"/> Inject
Other/Unknown:					<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Nasal <input type="checkbox"/> Inject

**Medications for Opioid Use Disorder:**  Acamprosate  Disulfiram  Naltrexone  Topiramate  Naltrexone  Buprenorphine  Methadone  None

**Current Dose:** \_\_\_\_\_ **OTP Clinic:** \_\_\_\_\_

**Current SUD Treatment Program:** \_\_\_\_\_  n/a

**Level of Care:**  4.0  3.7WM  3.7  3.5  3.1  2.5  2.1  1.0 **Date of Discharge:** \_\_\_\_\_

**Are you currently involved with the legal system?**  No  Pending  Yes **If yes, specify:**

Recovery Court  SPB  ISP  IDRC  DCPD  Federal Probation or Pretrial, Probation, etc.)  County Probation

**Officer's Name:** \_\_\_\_\_

**Officer's Phone:** \_\_\_\_\_ **Officers Email:** \_\_\_\_\_

**History of DUI:**  No  Yes If yes, what year: \_\_\_\_\_ **Driver's License #:** \_\_\_\_\_ **State:** \_\_\_\_\_