DRUG SCREENING
TREATMENT REFERRAL FORM

REFERRAL TO:	**REFERRAL FROM:**
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone #: _____	Phone #: _____

DATE OF REFERRAL:

INDIVIDUAL'S NAME:

DATE OF BIRTH: **SEX: ☐ Male ☐ Female**

INSURANCE CARRIER:

REASON FOR REFERRAL (Specific Information):

_____

_____

_____

OTHER KNOWN MEDICAL CONDITIONS/CONCERNS:

_____

_____

_____

SUBSTANCE INVOLVEMENT:

a. Tobacco products (cigarettes, chewing tobacco cigars, etc.	☐ Yes	☐ No
b. Alcoholic beverages (beer, wine, liquor, etc.)	☐ Yes	☐ No
c. Cannabis (marijuana, pot, grass, hash, etc.)	☐ Yes	☐ No
d. Cocaine (coke, crack, etc.)	☐ Yes	☐ No
e. Prescription stimulants (Ritalin, Concerta Dexedrine, Adderall, diet pills, etc.)	☐ Yes	☐ No
f. Methamphetamine (speed, crystal meth, ice, etc.)	☐ Yes	☐ No
g. Inhalants (nitrous oxide, glue, gas, paint thinner)	☐ Yes	☐ No
h. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	☐ Yes	☐ No
i. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	☐ Yes	☐ No
j. Street opioids (heroin, opium, etc.)	☐ Yes	☐ No
k. Prescription opioids (fentanyl, oxycodone (OxyContin, Percocet), hydrocodone (Vicodin), Methadone, buprenorphine, etc.)	☐ Yes	☐ No
l. Other - specify:	☐ Yes	☐ No

SUBSTANCE INVOLVEMENT SCORE

☐ Low Risk
☐ Moderate Risk
☐ High Risk

_____

INFORMED CONSENT FORM

☐ YES
☐ NO

SIGNATURE OF REFERRING PHYSICIAN: _____