First Choice Counseling Center
Substance Use Program Referral Form

Consumer Name:	D.O.B:	
Address:		
City:	State:	Zip:
Home Phone:	Cell #	
Medical Assistance/Medicaid #:		
Race:	Ethnicity:	
Marital Status:	Gender:	
Highest Educational Level:	Living Situation:	
Employment Status:	Veteran -Yes/ No, if yes, Dates and/or war service_____	
# of Arrests in past 30 days _____	Transition Age Youth: Yes/No	
Has the client recently been discharged from an outpatient mental health, substance use/ hospital? Yes No, If yes, have they provided a copy of the aftercare plan:		

Referral Source	
Agency Name:	Contact Person Name:
Address:	
Phone #:	Fax #:
Email Address:	

Substance Use Service Requested
□Evaluation □ 12 Hour Substance Use Program □ Outpatient Treatment □Intensive Outpatient Treatment (IOP)
Reason for Referral
Primary Substance of Abuse □Alcohol □Heroin/Opioids □Benzodiazepines□Marijuana□Cocaine □Other **Diagnosis:_____**

Total Years of Use	Length of Current Use	Age of First Use
Usual Route of Administration □Oral □Smoking □Inhalation □Injection □Other	Frequency of Use	Date Last Used

Completing By:

Print Name: _ _____

Signature_____ Date_____