LIFTING STIGMAS
CHANGING LIVES
OUTPATIENT MENTAL HEALTH CLINIC • COMMUNITY OUTREACH ORGANIZATION

Referral for Services SUD IOP/OP

Returning Consumer: ☐ **Yes** ☐ **No** **Date:** ______________

Consumer Information ONLY

Consumer Name:	Date of Birth:
SS#:	MA#:
Gender Assigned at Birth:	Gender Identity:
Sexual Orientation:	Phone Number:
Message OK? ☐ Yes ☐ NO	Email Address:
Living Situation:	Address:
City:	State/Zip code:
School/Grade (if applicable):	Address of School:
Preferred Method of Contact: ☐ Phone ☐ Text ☐ Email	Best Time to Call:
Are you Employed? ☐ Yes ☐ No	If yes, ☐ Supportive Employment ☐ PT ☐ FT

Referral Source Information

Name:	Agency (if applicable):
Phone Number:	Fax Number:
Email Address:	Relationship to Consumer:

Parent/Guardian Information:

Name of Parent/Guardian:	Relationship:
Address:	Contact Number:

A LEGAL DOCUMENT MUST BE PRESENTED TO SHOW GUARDIANSHIP
COURT ORDER/LEGAL DOCUMENTATION

Please answer the following:

Is the consumer of Hispanic, Latino, or Spanish origin?	☐ Yes ☐ No ☐ Unavailable
Race:	☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Not Available

How well does the consumer speak English?	☐ Well ☐ Not so well ☐ Not at all
Does the consumer speak another language other than English at home?	☐ Yes ☐ No
If Yes, what is the language?	☐ Spanish ☐ French ☐ Arabic ☐ Greek ☐ Other
Number of arrests in the past 30 days?	☐ None ☐ 1-99
Is the consumer deaf or do they have hearing difficulty?	☐ Yes ☐ No ☐ Unknown
Is the consumer blind or do they have serious difficulty seeing, even when they wear glasses?	☐ Yes ☐ No ☐ Unknown

REASON FOR REFERRAL/Primary Concerns:

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SUBSTANCES USE:

Type of Substance	Age at First Use	Route of Transmission	Frequency of Use	Date of Last Use

Currently Receiving Medication Assisted Treatment? ☐ Yes ☐ No	Clinic Name/Phone Number of MAT:
Mental Health Diagnosis:	Current Therapy/Treatment Supports: