REGION II HUMAN SERVICES

OPIOID & SUBSTANCE USE REFERRAL

REFERRAL SOURCE INFORMATION:

Date: _____ Referral Source Name/Agency: _____

Address: _____City: _____ Phone: _____

FAX: _____ Email: _____

CLIENT INFORMATION:

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____ County: _____

Phone: _____ Guardian Name & Phone (if applicable): _____

IMMEDIATE NEED:Briefly describe why the individual is being referred for opioid/substance use services:

_____

_____

_____

STATEMENT OF PROBLEM: Please describe the client's current situation, barriers, or presenting issues:

_____

_____

_____

Requested Services:

☐ Substance Use Counseling ☐ Medication-Assisted Treatment (MAT) ☐ Peer Recovery Support ☐ Family Support
☐ Support Group ☐ On-going Support ☐ Transportation ☐ Other: _____

Functional Deficits/Areas of Concern (Check all that apply):

☐ Substance Use ☐ Family ☐ Relationships ☐ Legal ☐ Daily Living ☐ Community Living Skills ☐ Vocational
☐ Disabilities ☐ Educational ☐ Transportation ☐ Self-Advocacy ☐ Treatment Seeking

Treatment History:

Past Psychiatric Hospitalizations: _____
Current Psychiatrist/Physician: _____
Current Diagnosis: _____
Other Service Providers/Programs: _____

Additional Notes/Safety Concerns:

_____

_____

_____

Submitted By: _____ **Date:** _____

All completed referral forms can be faxed to:
ATTENTION: FAMILY/SYSTEM NAVIGATOR **FAX #: 308-534-6961**