

This document may contain PHI. Please ensure HIPAA compliance by sending via secure email or fax.



Department of Health Services
Division of Behavioral Health Services
Substance Use Prevention and Treatment Services

Phone: 916-874-9754 Fax: 916-874-9806 3321 Power Inn Road, Suite 120, Sacramento, CA 95826 SUPTSOC@Saccounty.net

SUD universal referral form to adult system of care (SOC)

Referral information **Date of referral:** _____

Name of referring party: _____ Phone #: _____

E-mail: _____ Other: _____

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> Attorney/ DA office | <input type="checkbox"/> Correctional health | <input type="checkbox"/> EIFTC ** | <input type="checkbox"/> Mental health | <input type="checkbox"/> Prop 36 |
| <input type="checkbox"/> CalWORKs/DHA | <input type="checkbox"/> CPS social worker | <input type="checkbox"/> Hospital | <input type="checkbox"/> Parole | <input type="checkbox"/> Public defender |
| <input type="checkbox"/> Collaborative courts | <input type="checkbox"/> DFTC ** | <input type="checkbox"/> Jail social worker | <input type="checkbox"/> Probation | <input type="checkbox"/> STARS ** |

Client information (One form per client referred)

Client name: (last) _____ (first) _____ Primary language: _____

Male Female Other DOB: ____ / ____ / ____ Phone #: _____

Address: _____ City: _____ Zip Code: _____

History and recent events (check all that apply)

Substance use (check all that apply):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Admitted drug use | <input type="checkbox"/> DUI | <input type="checkbox"/> Mother positive at birth | <input type="checkbox"/> Prior CPS case with drugs |
| <input type="checkbox"/> Drug arrests | <input type="checkbox"/> Failure(s) to drug test | <input type="checkbox"/> Paraphernalia in home | <input type="checkbox"/> Prior pos-tox births |
| <input type="checkbox"/> Drugs found in home | <input type="checkbox"/> Infant positive at birth | <input type="checkbox"/> Prenatal exposure | <input type="checkbox"/> Prior SUD Tx history |

Drug(s) of choice related to qualifying events (check all that apply):

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Ecstasy/Club drugs | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Opiates |
| <input type="checkbox"/> Benzodiazepine | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cocaine/Crack | <input type="checkbox"/> Heroin | <input type="checkbox"/> Misuse of prescriptions | |

Criminal justice history (check all that apply): **Current incarceration:** Main Jail RCCC

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> 290 Registrant | <input type="checkbox"/> CNO eligible | <input type="checkbox"/> Hold from another county | <input type="checkbox"/> Intoxicated in public |
| <input type="checkbox"/> 452 Arson registrant | <input type="checkbox"/> Drug possession | <input type="checkbox"/> Intent to sell | <input type="checkbox"/> Pending drug charges |

Summary/Reason for referral: Specific details and dates of the above checked boxes, include AOD/SUD related history as well as treatment episodes, arrests, CPS, family, & domestic violence, and current drug test results including failure to test (s).

Date of last use: _____ Date of failure(s) to test: _____

Current drug use: Yes No Current AOD/SUD services: Yes No

Description of qualifying events and all previous AOD/SUD history: (Attach second page if needed)

** If DFTC/EIFTC/STARS are selected as referral source
Please submit referral to
intake@bridgesinc.net

Referral submitted to intake@bridgesinc.net