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

SUBMIT HERE

Phone: 916-874-9754 Fax: 916-874-9806 SUPT-YouthSOC@Saccounty.Gov

SUD Universal Referral Form to Youth System of Care (SOC)

Referral Information **Date of Referral:**

Name of Referring Party: _____ Phone #: _____

E-Mail: _____ Other: _____

☐ CLC Attorney ☐ CPS Social Worker ☐ Dept 90

☐ School ☐ Probation ☐ YDF ☐ Other: _____

Client Information *(One form per client referred)*

Client Name: (last) _____ (first) _____ Primary Language: _____

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

Address: _____ City: _____ Zip Code: _____

Caregiver information (if applicable):

Name: (last) _____ (first) _____

Phone #: _____ Primary Language: _____

Address: _____ City: _____ Zip Code: _____

Current Living Situation:

☐ Biological Home ☐ STRTP/Group Home ☐ Homeless Shelter

☐ Natural Support ☐ Foster Care Home ☐ Homeless on Street

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

☐ Alcohol ☐ Ecstasy/Club Drugs ☐ Marijuana ☐ Opiates

☐ Benzodiazepine ☐ Hallucinogens ☐ Methamphetamine ☐ Other:

☐ Cocaine/Crack ☐ Heroin ☐ Misuse of Prescriptions _____

SUMMARY/REASON for REFERRAL: Specific details and dates of the above checked boxes, include qualifying events.

Current Drug Use: ☐ Yes ☐ No Date of last use: _____

Describe Use and other concerns related to the referral:

Updated: April 2023