

Outpatient Substance Abuse Services Referral Form

Client Name: _____ Date of Birth: _____ Phone #: _____

Referral Source Information: (Please write name of person who needs progress reports.)

Referral Name: _____ Work Number: _____

Email Address: _____ Fax Number: _____

Recommended Services:

- ☐ **DUI Assessment** – Consists of one 2 ½ hour session
- ☐ **Substance abuse Evaluation** – Consists of one 2 ½ hour session
- ☐ **DUI Outpatient Programs**
 - ☐ 6-week program
 - ☐ 12-week program
 - ☐ 20-week program
- ☐ **Relapse Prevention/Aftercare Programs**
 - ☐ 6-week program
 - ☐ 12-week program
 - ☐ 20-week program
- ☐ **Cognitive Behavioral Skills Program** – 12-24-week program for adults, designed to challenge and correct irresponsible thinking and behavior, 1 ½ hours per week.
- ☐ **Anger Management/Coping Skills Program** – 12-week program for adults, 1 ½ hours per week.
- ☐ **Early Intervention Programs** – 6-week substance abuse education program for adults.
- ☐ **Extended Outpatient Programs** – 12-24-week program (2-8 hours per week) for adults. Individual, group, and self-help meeting attendance is required.
- ☐ **Intensive Outpatient Programs** – 6-week intensive program (9 hours per week) for adults. Individual, group, and self-help meeting attendance is required.

Parenting Programs – 16-week parenting program focusing on parenting issues with parents who have substance abuse issues.

Level of Identified Risk: (Level checked indicates the risk of relapse/continued use or other behavioral/family problems)

- ☐ **Low Risk** – (Risk is minimal) Early Intervention referral is indicated
- ☐ **Medium Risk** – (Risk is moderate) Extended Outpatient referral with additional family services is indicated
- ☐ **High Risk** – (Risk is extreme) Intensive Outpatient referral with additional family services is indicated

Case history, evaluation results, or comments supporting assigned level of risk:

Referral Source Signature: _____ Date: _____