SUBSTANCE USE DISORDER REFERRAL

Completed referral forms should be faxed to (240) 341-3505 or emailed to info@continuousgrowth.org. For more information, please contact the main office at 410-600-3349.

REFERRAL SOURCE INFORMATION

Date of Referral: _____ Referral Name: _____

Referring Agency: _____ Referral Phone: _____

Email Address: _____ Fax Number: _____

CONSUMER INFORMATION

Consumer Name: _____ **Gender Identity:** _____

Marital Status: _____ **SSN:** _____

DOB: _____ **Age:** _____ **Race:** _____

Medical Assistance #: _____

Legal Guardian: _____

Full Address: _____

Phone: _____ **Alternate Phone:** _____

# of Dependents: _____ **Highest Level of Education:** _____

Currently Employed: ☐ Y ☐ N

Military Experience: No Yes, if so what branch: _____ **Still Active:** ☐ Y ☐ N

Active Insurance: ☐ Y ☐ N **Insurance Type:** ☐ Medicaid ☐ Medicare ☐ Private ☐ None

Registered Sex Offender: ☐ Y ☐ N **Currently on Parole/Probation:** ☐ Y ☐ N

Cigarette Use: ☐ Y ☐ N

Prescribed Medication: ☐ No ☐ Yes, if so list: _____

History:

Number of Arrest in Last 30 Days: _____ Number of Arrest in Last 12 months: _____

Medical Challenges: _____ Physical Disabilities: _____

# of Treatment Episodes: _____ Primary Source of Income: Employment TCA SSI SSDI Retirement Other None

History of Mental Illness: _____

Primary Substance: _____ Age of 1st Use: _____

CONTINUOUS GROWTH

Date of Last Use:_____ Method of Use: ☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other

Length of Current Use: ☐ 1 month or less ☐ 1-6 months ☐ 6 months-1 yr ☐ 1yr or more ☐ Unknown

Total Yrs. Of Use: _____ How Often: _____ How Much: $_____

Withdraw Symptoms: _____ Longest Period of Abstinence: _____

Secondary Substance_____ Age of 1st Use: _____

Date of Last Use:_____ Method of Use: ☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other

Length of Current Use: ☐ 1 month or less ☐ 1-6 months ☐ 6 months-1 yr ☐ 1yr or more ☐ Unknown

Total Yrs. Of Use: _____ How Often: _____ How Much: $_____

Withdraw Symptoms: _____ Longest Period of Abstinence: _____

Tertiary Substance: _____ Age of 1st Use: _____

Date of Last Use:_____ Method of Use: ☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other

Length of Current Use: ☐ 1 month or less ☐ 1-6 months ☐ 6 months-1 yr ☐ 1yr or more ☐ Unknown

Total Yrs. Of Use: _____ How Often: _____ How Much: $_____

Withdraw Symptoms: _____ Longest Period of Abstinence: _____

Problem Areas:

☐ Educational	☐ Health Care	☐ Legal
☐ Primary Support	☐ Housing	☐ Social Environment
☐ Occupational	☐ Homeless	☐ Unknown

Comments: _____

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Information Provided By: _____ Date: _____