Sacramento County
Department of Health and Human Services - Alcohol and Drug Services Division

Alcohol and Other Drug (AOD) Screening and Service Referral

Client Information

Client Name: (last) _____ (first) _____ Today's Date: ☐☐ / ☐☐ / ☐☐
Please Print Please Print (Month) (Date) (Year)

☐ Male ☐ Female DOB: ☐☐ / ☐☐ / ☐☐ SSN: ☐☐☐ - ☐☐ - ☐☐☐☐
(Month) (Date) (Year)

Race/Ethnicity: _____

Address: _____ City: _____ Zip Code: _____

Area of Residence: **(check one)**
☐ Midtown ☐ Broadway/Oak Park ☐ East (e.g. Rancho) ☐ Northwest (e.g. Del Paso)
☐ Central (e.g. Arden) ☐ South ☐ Northeast (e.g. Citrus Heights)

Referrer's Information

Staff Name: _____ Worker Code: _____ Phone: _____ FAX: _____

Mail Code: _____ Address (if no Mail Code): _____

Referrer's Affiliation: **(check one)**
☐ AOD-County/SOC ☐ AOD-CalWORKs ☐ AOD-Prop 36 ☐ AOD-Provider
☐ AOD-STARS ☐ CPS-EIS/DDC ☐ CPS-EIS/IS ☐ CPS Other
☐ M.H.-CalWORKs ☐ M.H.-Other ☐ Public Health ☐ Other: _____

AOD Screening and Basis For Further Assessment

Check all that apply:

☐ CPS Assessment tool (specific to AOD use) indicates risk as: ☐ low ☐ moderate ☐ high

☐ Screening tool (e.g. CAGE, SASSI, etc.) indicates AOD problem. Tool used: _____

Results: _____

☐ Behaviors related to AOD problems (specify): _____

_____

_____

☐ Other (specify): _____

_____

_____

Services Requested

☐ Assessment by Alcohol and Drug Services Division

☐ Treatment Placement/Authorization by the Alcohol and Drug Services Division

☐ Other: _____

_____

To expedite treatment placement/authorization by the Alcohol and Drug Services Division, staff and providers who have completed Level I and Level II of AODTI training have the option of completing the AOD Preliminary Assessment.

Exchange of Information

Authorization for Exchange of Information (42 C.F.R. & 45 C.F.R.)

Alcohol and Drug Treatment: These records are protected under federal law and cannot be disclosed without your written authorization. Re-disclosure of these records is not allowed, except in compliance with state or federal law, or with your written permission. I understand that the Alcohol and Drug Services Division will be providing my Protected Health Information (PHI) to the party stated below. If I choose not to authorize this disclosure of my PHI, the Alcohol and Drug Services Division may not provide that PHI to the party stated below and I may not be able to show I qualify for these services.

Authorization is hereby given for the exchange of information regarding **(print client's name)** _____
between the Sacramento County Department of Health and Human Services Alcohol and Drug Services Division and

_____
for further assessment, treatment placement, treatment authorization, payment or treatment status. This consent will expire one year from the date of signature or upon client's written request for change.

_____ _____ _____ _____
Client's Signature Date Assessor's Signature Date

Original: Alcohol and Drug Services Division
Mail to 13-149D or FAX to 874-9806

Copy: Provider **Yellow: Referral Source** **Pink: Client**