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

Phone: 916-875-2050 SUPT-YouthSOC@Saccounty.Gov

SUD Youth Referral Form

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: August 2024