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

Phone: 916-874-9754 Fax: 916-874-9806

SUPTSOC@Sacounty.gov

SUD universal referral form to adult system of care (SOC)

Referral information **Date of referral:** _____

Name of referring party: _____ Phone #: _____

E-mail: _____ Other: _____

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> Attorney/ DA office | <input type="checkbox"/> Correctional health | <input type="checkbox"/> EIFTC ** | <input type="checkbox"/> Mental health | <input type="checkbox"/> Prop 36 |
| <input type="checkbox"/> CalWORKs/DHA | <input type="checkbox"/> CPS social worker | <input type="checkbox"/> Hospital | <input type="checkbox"/> Parole | <input type="checkbox"/> Public defender |
| <input type="checkbox"/> Collaborative courts | <input type="checkbox"/> DFTC ** | <input type="checkbox"/> Jail social worker | <input type="checkbox"/> Probation | <input type="checkbox"/> STARS ** |

Client information (One form per client referred)

Client name: (last) _____ (first) _____ Primary language: _____

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

Address: _____ City: _____ Zip Code: _____

History and recent events (check all that apply)

Substance use (check all that apply):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Admitted drug use | <input type="checkbox"/> DUI | <input type="checkbox"/> Mother positive at birth | <input type="checkbox"/> Prior CPS case with drugs |
| <input type="checkbox"/> Drug arrests | <input type="checkbox"/> Failure(s) to drug test | <input type="checkbox"/> Paraphernalia in home | <input type="checkbox"/> Prior pos-tox births |
| <input type="checkbox"/> Drugs found in home | <input type="checkbox"/> Infant positive at birth | <input type="checkbox"/> Prenatal exposure | <input type="checkbox"/> Prior SUD Tx history |

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

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Ecstasy/Club drugs | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Opiates |
| <input type="checkbox"/> Benzodiazepine | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cocaine/Crack | <input type="checkbox"/> Heroin | <input type="checkbox"/> Misuse of prescriptions | |

Criminal justice history (check all that apply): **Current incarceration:** **Main Jail** **RCCC**

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> 290 Registrant | <input type="checkbox"/> CNO eligible | <input type="checkbox"/> Hold from another county | <input type="checkbox"/> Intoxicated in public |
| <input type="checkbox"/> 452 Arson registrant | <input type="checkbox"/> Drug possession | <input type="checkbox"/> Intent to sell | <input type="checkbox"/> Pending drug charges |

Summary/Reason for referral: Specific details and dates of the above checked boxes, include AOD/SUD related history as well as treatment episodes, arrests, CPS, family, & domestic violence, and current drug test results including failure to test (s).

Date of last use: _____ Date of failure(s) to test: _____

Current drug use: Yes No Current AOD/SUD services: Yes No

Description of qualifying events and all previous AOD/SUD history: (Attach second page if needed)

** If DFTC/EIFTC/STARS are selected as referral source
Please submit referral to
intake@bridgesinc.net

Referral submitted to intake@bridgesinc.net