

Drug Screening Treatment Referral Form

REFERRAL TO:	REFERRAL FROM:
Name:	Name:
Address:	Address:
Phone #:	Phone #:

Date of Referral:	
Individual's Name:	
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Insurance Carrier:	
Reason for Referral (Specific Information):	
Other Known Medical Conditions/Concerns:	

Any immediate family members with substance abuse or prescribed opioids?

YES NO

SUBSTANCE INVOLVEMENT

- | | | |
|--|------------------------------|-----------------------------|
| a. Tobacco products (cigarettes, chewing tobacco, cigars, e-cigarettes, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| b. Alcoholic beverages | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| c. Cannabis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| d. Cocaine | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| e. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| f. Methamphetamine (speed, crystal meth, ice, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| g. Inhalants (nitrous oxide, glue, gas, paint thinner) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| h. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| i. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| j. Street opioids (heroin, opium, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| k. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], Methadone, buprenorphine, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| l. Other – specify: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

SIGNATURE OF REFERRING PHYSICIAN:

PATIENT SIGNATURE: