Latino Community
Development Agency
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Outpatient Substance Abuse Referral Form

Client Information

Name: DOB: Gender:

Phone: Email:

Court Case #: KK# (DHS, CW Only):

Referring Agency:
Contact Person: Phone: Email:

___ Self Referred

1. Service Needed by: ___________ (Date)

2. Insurance Coverage: _____ Medicaid/ Medicare _____Self-Paid
   Medicaid #:

3. Preferred Language for Services: ___ English ___ Spanish

4. Mark Referral Program:

   ___ Adolescent/Adult Substance Abuse Treatment
   ___ Drug Testing
   ___ Alternative Suspension Program

5. Court/DHS Related Assessment Services:

   ___ Substance Abuse Evaluation

6. Level of Identified Risk: *(Level checked indicates the risk of relapse/continued use or other behavioral/family problems)*

   ___ Low Risk ___ Medium Risk ___ High Risk

7. Reason for referral: