Latino Community Development Agency, Inc.
Latino Client Services
Main Office: 405-236-0701 Main Fax: 405.236.0737
420 SW 10th Street / Oklahoma City, OK 73109

Outpatient Substance Abuse Referral Form

CLIENT INFORMATION

Name:______________________ DOB: ____ / ____ / ____ Gender: _____ F _____ M

Phone: ______________________ Email: ______________________

Address: ______________________ City: ________________ County: _________________

State: ________________ Zip Code: _________________

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

REFERRING AGENCY

Agency Name: ______________________ Contact Person: ______________________

Phone: ______________________ Email: ______________________

_____ Self-Referred

SERVICES NEEDED

_____ Self-Referred

1. Services Needed by: ________________ (Date) Frequency: ________________
2. Insurance Coverage: _____ Medicaid/Medicare _____ Self-Pay
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

Describe Reason for Referral: ____

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Updated 8/12/20