

Structured Treatment Program

Referral Form

Date of Referral: _____

Referral Source: _____

Address: _____

Phone Number: _____

Email Address: _____

Date of Program: _____

Women _____ Men _____

Client Name: _____

File # _____

Address: _____

D.O.B. _____

MM DD YY

HC# _____

Phone: _____ Messages allowed? Yes No

Along with this completed referral form, I am sending:

A comprehensive standard assessment completed within the last 3 months

Or

A comprehensive assessment completed within the last year, plus a letter noting any pertinent updates in the client's situation and treatment.

Short Intake completed on Assist _____

Date

Program information sheet reviewed with client Yes _____

Client has follow up appointment with clinician within 10 working days following program end date Yes _____

Drug/Activity of Choice _____

Last Use _____

Medical Concerns/Allergies

Please list all medications/dosage client is currently taking

Is this client currently on Methadone Maintenance Yes _____ No _____

If yes, daily dose _____

If the client you are referring is a client of the Methadone Maintenance Program, please place your initials on the line below to indicate the corresponding Methadone Maintenance Clinic Staff have been made aware of this referral _____

If client is accepted to the program, the referring clinician will be responsible for arranging methadone carries for the client. STP staff will be responsible for pharmacy pick-ups only in the industrial area only.

Please indicate client's periods of sobriety in the last two years
