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

SIGNATURE OF REFERRING PHYSICIAN:

PATIENT SIGNATURE: