

SUBSTANCE USE DISORDER REFERRAL

Completed referral forms should be faxed to (240) 341-3505 or emailed to info@continuousgrowth.org. For more information, please contact the main office at 410-600-3349.

REFERRAL SOURCE INFORMATION

Date of Referral: _____ Referral Name: _____
Referring Agency: _____ Referral Phone: _____
Email Address: _____ Fax Number: _____

CONSUMER INFORMATION

Consumer Name: _____ **Gender Identity:** _____

Marital Status: _____ **SSN:** _____

DOB: _____ **Age:** _____ **Race:** _____

Medical Assistance #: _____

Legal Guardian: _____

Full Address: _____

Phone: _____ **Alternate Phone:** _____

of Dependents: _____ **Highest Level of Education:** _____

Currently Employed: Y N

Military Experience: No Yes, if so what branch: _____ **Still Active:** Y N

Active Insurance: Y N **Insurance Type:** Medicaid Medicare Private None

Registered Sex Offender: Y N **Currently on Parole/Probation:** Y N

Cigarette Use: Y N

Prescribed Medication: No Yes, if so list: _____

History:

Number of Arrest in Last 30 Days: _____ Number of Arrest in Last 12 months: _____

Medical Challenges: _____ Physical Disabilities: _____

of Treatment Episodes: _____ Primary Source of Income: Employment TCA
 SSI SSDI Retirement Other None

History of Mental Illness: _____

Primary Substance: _____ **Age of 1st Use:** _____

CONTINUOUS GROWTH

Date of Last Use: _____ Method of Use: Oral Smoking Inhalation Injection Other
Length of Current Use: 1 month or less 1-6 months 6 months-1 yr 1yr or more Unknown
Total Yrs. Of Use: _____ How Often: _____ How Much: \$ _____
Withdraw Symptoms: _____ Longest Period of Abstinence: _____

Secondary Substance _____ Age of 1st Use: _____
Date of Last Use: _____ Method of Use: Oral Smoking Inhalation Injection Other
Length of Current Use: 1 month or less 1-6 months 6 months-1 yr 1yr or more Unknown
Total Yrs. Of Use: _____ How Often: _____ How Much: \$ _____
Withdraw Symptoms: _____ Longest Period of Abstinence: _____

Tertiary Substance: _____ Age of 1st Use: _____
Date of Last Use: _____ Method of Use: Oral Smoking Inhalation Injection Other
Length of Current Use: 1 month or less 1-6 months 6 months-1 yr 1yr or more Unknown
Total Yrs. Of Use: _____ How Often: _____ How Much: \$ _____
Withdraw Symptoms: _____ Longest Period of Abstinence: _____

Problem Areas:

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Educational | <input type="checkbox"/> Health Care | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Primary Support | <input type="checkbox"/> Housing | <input type="checkbox"/> Social Environment |
| <input type="checkbox"/> Occupational | <input type="checkbox"/> Homeless | <input type="checkbox"/> Unknown |

Comments: _____

Information Provided By: _____ Date: _____