The Seventy Times Seven Wellness Mission
2107 N Charles St Baltimore MD 21218 * 410-624-5037 (office) * 800-405-6914 (fax)

SUD TREATMENT REFERRAL FORM

Client Information:

Client Name: _____ **Phone #:** _____

Current Address: _____
Address, City, State, Zip

Date of Birth: _____

Medicaid: yes ☐
no ☐
(*PRP services can only be billed through MD Medicaid)*

Referral Source Information:

(Please write name of person who needs progress reports, incident reports,etc.)

Therapist Name: _____ **Credentials:** _____

Street Address: _____
Address, City, State, Zip

Email Address: _____ **Fax Number:** _____

Client Treatment Information:

Drug of choice : _____ **Last used:** _____

How often: (ex. 1x/wk., 3-5x/wk. 1x/mo. etc.) _____

How much: (ex.$10.00 worth, 2 12oz. beers etc.) _____

Withdrawal Symptoms: ☐ **Yes** ☐ **No**

Longest period of abstinence: _____

Military History: _____ **Branch:** _____ **Tours of Duty:** _____

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Number of arrest in last 30 days : _____ **Number of arrest in last 12 months :** _____

Number of Dependent Children: _____

How much: (How Much: (ex.$10.00 worth, 2 12oz. beers etc.) _____

Physical Disabilities: _____
(ex. Difficulty hearing, speaking, talking, walking etc.)

Medical Challenges : _____

Education completed: _____

Recommended Services

☐ **Substance Abuse Evaluation:** Consists of one, 2 hour session

☐ **Outpatient Treatment:** 12-18 week program (6-8 hours per week) for adults. Random Drug Testing, individual, group, and self-help meeting attendance is required.

☐ **Intensive outpatient:** 12-24 week intensive program (9-12 hours per week) for adults. Individual, group, and self-help meeting attendance is required. Random Drug Testing required.

Once this form is complete please fax to 800-405-69014
ATTENTION: Intake Coordinator

Referral Source Signature: _____ **Date:** _____