



515 Bridge Street  
Park Rapids, MN 56470  
218-366-9229 phone  
218-237-2520 fax

## Substance Use Disorder Services Referral Form

Today's Date: \_\_\_\_\_ Referring Program: \_\_\_\_\_ Referring Person: \_\_\_\_\_

Why Referring? \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Contact #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Homeless? Yes/No

IV Drug User? Yes No Pregnant? Yes No

Previous:  Diagnostic Assessment  Rule 25 Assessment  Comprehensive Assessment

Where: \_\_\_\_\_ When: \_\_\_\_\_ If yes, we will need a copy

Where: \_\_\_\_\_ When: \_\_\_\_\_ If yes, we will need a copy

Court Ordered?  Yes  No Which County? \_\_\_\_\_

Probation Officer?  Yes  No Who? \_\_\_\_\_ County? \_\_\_\_\_

Case Manager?  Yes  No Who? \_\_\_\_\_ County? \_\_\_\_\_

CHIPS Worker?  Yes  No Who? \_\_\_\_\_ County? \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Current Providers:

Who? \_\_\_\_\_ Where? \_\_\_\_\_ For? \_\_\_\_\_

Who? \_\_\_\_\_ Where? \_\_\_\_\_ For? \_\_\_\_\_

Who? \_\_\_\_\_ Where? \_\_\_\_\_ For? \_\_\_\_\_

Any transportation barriers?  Yes  No Explain: \_\_\_\_\_

SUDS Date Reviewed: \_\_\_\_\_ Accept or Refer Assigned Clinician: \_\_\_\_\_

Scheduled On: \_\_\_\_\_ Site: \_\_\_\_\_ Service Type: \_\_\_\_\_