COMUNIDADES LATINAS UNIDAS EN SERVICIO

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Referral Request for CLUES MI/SUD Services

Please note: Due to the confidential nature of this request, an informed release of information form must be signed by the client and forwarded with this referral. If a client is being referred for MI/SUD Outpatient Treatment, please attach a Comprehensive Assessment that is not more than 3/6 months old.

Date of Referral: _____

Referring Agency: _____

Referring Contact: _____ **Phone:** _____ **Fax:** _____

Please Check Preferred CLUES Location for Evaluation and Treatment:

❑ CLUES in St. Paul	(612) 429-0767	Fax: (612) 887-1430
❑ CLUES in Minneapolis	(612) 404-2600	Fax: (612) 887-1430

Client's Medical Information (please print)

Client Referred: _____ **DOB:** _____
(Last, First, MI) (Phone)

Client/Guardian_____
(Name) (Phone)

Address: _____

Requested CLUES Outpatient MI/SUD Service:

- ❑ Comprehensive Assessment
- ❑ MADD Panel
- ❑ Outpatient Individual / Group Counseling-Co-Occurring (Substance Abuse and Mental Health) Services

Reason for the Client's Referral:

_____
_____
_____
_____
_____

SUBSTANCE ABUSE ASSESSMENT FORM

Instructions for use: Complete this form and use these questions to guide the client interview when to determine a client's treatment needs. Thank you.

Substances used and history:

Substances	Never Used	Currently Using	Past Use	Age first Used
Alcohol				
Prescription stimulants (Ritalin, Concerta Dexedrine, Adderall, diet pills, etc.)				
Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)				
Cocaine/crack				
Heroin/morphine				
Inhalants (nitrous oxide, glue, gas, paint thinner)				
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)				
Marijuana/hash				
Methamphetamine (speed, crystal meth, ice, etc.)				
Nicotine (cigarettes, chewing tobacco, cigars, e-cigarettes, etc.)				
Street opioids (heroin, opium, etc.)				
Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], Methadone, buprenorphine, etc.)				
Other (specify) _____				

Describe type, amount, and frequency of use for each substance indicated above:

_____

_____

_____

_____

_____

1. **Has client used drugs and/or alcohol in situations where it is physically dangerous, such as driving while impaired? □ *Yes* □ *No***

If Yes, describe: _____

_____

2. **Has client been intoxicated, hungover, or in withdrawal at times when he/she is expected to fulfill important obligations, such as while at work? □ Yes □ No**

If Yes, describe: _____

_____

3. **Has client given up occupational, social, or recreational activities because of substance use?**
   □ *Yes* □ *No*

If Yes, describe: _____

_____

4. **Has client used drugs and/or alcohol to ease difficulties with emotions, relationships, or as a stress reliever?**

□ *Yes* □ *No*

If Yes, describe: _____

_____

5. **Work problems: □ Violation of the Employer's substance abuse policy, example: a positive drug test. □ Absenteeism □ Tardiness □ Accidents□ Working while hung-over □ Trouble concentrating □ Decreased job performance □ Consumed substances while at work□ Lost job in past due to substance abuse □ No work problems**

Comments: _____

_____

_____

6. **Client's perception of substance use:**

□ *Not a problem* □ *Unsure if problem* □ *Some problem* □ *Significant problem*□ *Severe problem* □ *Actively wants help*

7. **Family problems that are pre-existing, or are exacerbated by substance use:**

□ *Quarrels* □ *Domestic Violence* □ *Family abuses alcohol/ drugs*□ *Child Abuse* □ *Child Neglect* □ *Family worried about client's use*□ *Separated* □ *Divorce* □ *None*

8. **Legal problems:**

□ *DUI* □ *Public intoxication* □ *Other substance-related arrest* □ *None*

Other (specify) _____

9. **Financial problems: □*Some* □ *Moderate* □*Severe* □ *None***

Describe:_____

10. **Social problems: □*Some* □ *Moderate* □*Severe* □ *None***

Describe: _____

11. **Mental health disorders that are pre-existing, or have been exacerbated by substance use:**

_____

_____

_____

12. **Physical or medical problems:**

□ *Increased tolerance* □ *Hangovers* □ *Liver disease* □ *Stomach ailments* □ *Experiences withdrawal symptoms* □ *Heart ailments* □ *Blackouts* □ *Other medical problems*

Comment:

_____

_____

13. Medications currently being prescribed (specify):

_____

_____

14. Evidence of psychological dependence to substances? □ *Yes* □ *No*
Comment:

_____

_____

15. Has the client attempted to cut down or stop alcohol and drug use: □ *Yes* □ *No*
(Describe)_____

_____

16.* Control over use*: □ No loss of control □ Uses more than intends □ Getting worse □ Unpredictable.
□ Uses to get high □ Gets argumentative□ Increased tolerance

17. History of suicide attempts (describe):

_____

_____

18. History of violent behavior (describe):

_____

_____

19.* Previous treatment: □ *None* □ *Yes
(Describe: date, type, setting, and outcome)

_____

_____

20. Reports from collateral contacts (spouses, family, friends) concerning the client's substance use:

_____

_____

_____

Additional comments:

_____

_____

_____

_____

Referring Signature: _____Date: _____

Thank you.

PLEASE SUBMIT REFERRAL TO:

mhintake@clues.org
or
Fax: (612) 887-1430