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.

Check boxes for adult and adolescent referral.

Adult referral ☐ **Adolescent referral** ☐

Date of Referral: _____

Referring Agency: _____

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

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

Client/Guardian: _____
(Name) (Phone)

Address: _____

County: _____ **Client's preferred language:** _____

Ethnicity: _____ **Gender:** _____

Does the client have insurance? If yes, what kind?

_____

Requested CLUES Outpatient MI/SUD Service:

☐ **Comprehensive Assessment**

☐ **MADD Panel**

☐ **Outpatient Individual / Group Counseling-Co-Occurring (Substance Abuse and Mental Health) Services**

Insurance Name: _____

ID Number: _____

PMI Number: _____

Self-Pay:

☐ **Yes**

☐ **No**

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Reason for the Client's Referral/Clinical presentation/Client's concerns:
Describe the history of alcohol and/or substance use, and indicate the type, amount, and frequency of use for each substance. Examples are alcohol, cocaine, heroin, methamphetamines, fentanyl, etc. Also, describe the reason for referral, the client's clinical presentation, and the client referring person's personal concerns.

_____

_____

_____

_____

1. Client's perception of substance use:
☐ ***Not a problem*** ☐ ***Unsure if problem*** ☐ ***Some problem*** ☐ ***Significant problem*** ☐ ***Severe problem*** ☐ ***Actively wants help***

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

_____

_____

3. **Legal problems:**
☐ ***DUI*** ☐ ***Public intoxication*** ☐ ***Other substance-related arrest*** ☐ ***None***
Other (specify) _____

4. Mental health disorders that are pre-existing or have been exacerbated by substance use. Include the history of self-injurious behavior (*describe*), suicide attempts (*describe*), and violent behavior (*describe*):

_____

_____

_____

5. Physical or medical problems:
☐ ***Increased tolerance*** ☐ ***Hangovers*** ☐ ***Liver disease*** ☐ ***Stomach ailments***
☐ ***Experiences withdrawal symptoms*** ☐ ***Heart ailments*** ☐ ***Blackouts***
☐ ***Other medical problems***
***Comment*:**

_____

_____

6. Medications currently being prescribed (specify):

_____

_____

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7. **Previous treatment (including mental health):** ☐ ***None*** ☐ ***Yes***
(Please describe and indicate completion).

_____

_____

8. ***Who can we contact to get information about the client (include name and contact info)?***

_____

_____

_____

Additional comments:

_____

_____

_____

_____

Referring Signature: _____ ***Date:*** _____

If you have questions, please call us at (612) 404-2600. Thank you.

CLUES in St. Paul, 797 E. 7th St., St. Paul, MN 55106.
CLUES in Minneapolis, 2600 E 25th St, Suite B, Minneapolis, MN 55406

PLEASE SUBMIT REFERRAL TO:
mhintake@clues.org
or
Fax: (612) 887-1430