Santa Clara Valley Health & Hospital System
Department of Alcohol & Drug Services Adult Managed Care System

CONTINUUM OF CARE REFERRAL SUMMARY

Client Name:		Today's Date:
Client Phone Number:	Admit Date:	UNI/Care #:
Counselor Name:		Phone #:
Referring Provider:		Fax #:
Next Tx Provider (If known):		Intake Appt. (Date/Time):

Requesting Services/Referral To (check **one** and complete the information requested):

Different Tx Provider ☐ (Name):	Intake Appt. Date/Time:
Psych Eval ☐	THU ☐

1. Acute Intoxication/Withdrawal Potential **H** ☐ **M** ☐ **L** ☐

2. Biomedical Conditions/Complications **H** ☐ **M** ☐ **L** ☐

Pregnant During Treatment? Y ☐ N ☐ NA ☐

3. Psychological/Emotional/Behavioral/Cognitive Conditions **H** ☐ **M** ☐ **L** ☐

Purpose of Psych Referral: Confirm Diagnosis ☐ Med Eval ☐ Med Monitoring ☐ Tx Planning

(For Psych & All Case Mgmt Referrals: Indicate problematic sx/behaviors, current meds; MH history, specific CMgmt needs)

CONTINUUM OF CARE REFERRAL SUMMARY

4. Treatment Readiness **H** ☐ **M** ☐ **L** ☐

Stage of Change: Precontemp ☐ Contemp ☐ Preparation ☐ Action ☐ Maint ☐ Relapse ☐

5. Relapse/Continued Use/Problem Potential **H** ☐ **M** ☐ **L** ☐

6. Recovery Environment: **H** ☐ **M** ☐ **L** ☐

CJS/Dependency Crt Status:

Next Crt Date:

Financial/Employment Status:

Community Support/Transitional Plan **(Required if client will enter a THU *before* Outpatient Treatment)**:

Attachments/Consents Included? Y ☐ N ☐

TB Documentation Included? Y ☐ N ☐

Counselor Signature: Date: