

Confidential Client Information

SUD Referral and Tracking Form

Section 1: Completed by Individual Requesting SUD Screening										
Requestor's Name:					Requestor's E-mail:					
Department/Agency:					Office Phone:		Fax:			
Location Name and Add	ress:									
Date of Referral:		Name of Clie	ent:		Client's Date of Birth:					
Client's Gender: Male Transgender (F to M)		Female nder (M to F)	Unknown	Is the Client	Pregnant: □Yes □No Client's phone number:					
Client's email:					Case/Program Identifying #:					
Select Program(s) or Population(s) that best fits with the client:	ulation(s) that best		Mental Health Family Solutions Center MAMA's Neighborhood CalWORKS		Mainstream Services Interim Housing Project Roomkey Homeless Outreach / Encampments Permanent Supportive Housing		□ Other, specify:			
Refer the client directly	<mark>to the CE</mark>	ENS counselor	at assigned o		nformation is known. Otherwise you listed below.	<mark>ı may ref</mark>	er the client to one of the CENS			
CENS Providers and S	ites									
 SPA 1: Tarzana Treatmer (661) 726-2630 (Phone) (661) 723-3211 (FAX) □ Co-Located Site Specify Facility name and 	 SPA 3: Prototypes (626) 444-0705 (Phone) (626) 444-0710 (FAX) Co-Located Site Specify Facility Name and Address: 			 SPA 5: Didi Hirsch Mental Health Services (310) 895-2300 (Phone) (310) 895-2353 (FAX) Co-Located Site Specify Facility Name and Addres 		SPA 7: Los Angeles Centers for Alcohol and Drug Abuse (562) 273-0462 (Phone) (562-273)-0013 (FAX) Co-Located Site Specify Facility Name and Address:				
 ☑ SPA 2: San Fernando Valley Community Mental Health Center (818) 285-1900 (Phone) (818) 285-1906 (FAX) □ Co-Located Site Specify Facility Name and Address: □ Co-Located Site Specify Facility name and Address: 		ne))	 SPA 6: Special Service for Groups (323) 948-0444 (Phone) (323) 948-0443 (FAX) Co-Located Site Specify Facility Name and Addres 		SPA 8: Behavioral Health Services (310) 973-2272 (Phone) (310) 973-7813 (FAX) Co-Located Site Specify Facility Name and Address:					
I agree to schedule an appointment at one of CENS site and show up to the referred treatment site for SUD assessment and treatment services determined by the CENS										
counselor.										
Signed:		Client			_ Date:					
Signed:Referral Requestor					Date:					





Section 2: Completed by CENS counselor														
Client has Medi-Cal or My Health LA:	☐ If yes, Medi-Cal or My Health LA #:		☐ If no, Application #: S		ubmitted on:			Client's Sage Member ID Number: Sage Referral ID Number (auto generated in Sage)						
SUD Screening Completed by CENS Counselor:														
Date of Scree		Screen					Phone:							
CENS Agence	CENS Agency: Email:													
For CENS Counselors only - SUD Screening Results Based on the American Society of Addiction Medicine (ASAM) Triage Tool the CENS Counselor recommends the following Provisional Level of Care (LOC):														
SCREENED NEGATIVE OR EARLY INTERVENTION FOR TREATMENT														
→WAS AT RISK EDUCATION WORKSHOPS PROVIDED? □ Yes □ No														
SCREENED POSITIVE FOR OUTPATIENT TREATMENT SCREENED POSITIVE FOR INPATIENT TREATMENT														
	□ ASAM Level 1.0: Outpatient Services						□ ASAM Level 3.7-WM: Medically Monitored Inpatient WM							
 ASAM Level 2.1: Intensive Outpatient Services ASAM Level 1-OTP: Opioid (Narcotic) Treatment Program 						ASAM Level 4-WM: Medically Managed Intensive Inpatient WM								
		,		•										
ASAM Level 1-WM: Ambulatory WM without Extended On- Site Monitoring REFERRED TO OTHER SUPPORT SERVICES														
	SCREENED POSITIVE FOR RESIDENTIAL TREATMENT													
	evel 3.1: Low-Intensity R			ASAM 1.0, 2.1, 1-OTP, or 1-WM)										
□ ASAM Level 3.3: High-Intensity Residential Services, Population-Specific □ Other (Specify):														
	□ ASAM Level 3.5: High-Intensity Residential Services, Non-													
	on Specific													
	evel 3.2-WM: Clinically N	lanaged	Residen											
Client Referred to SUD Treatment: Yes No Refused If Yes, complete the following information:														
Name of Trea	atment Agency:													
Address:							F	Phone:						
Contact Pers	on:				Em	nail:								
Appointment	Date:			Tin	ne:									
Appointment Date: Time:														
If client is referred to SUD treatment, please complete Release of Information (ROI) form														
ROI – In Network Provider, ROI – Out of Network														
The Release of Information (ROI) form has been signed. □ Yes □ No														
Section 3: Treatment Provider Must Complete this Section and Return to CENS														
Client showed up to appointment: Yes No If no, rescheduled to: Date Time														
	lifferent than the ASAM Co-Triage	LOC,		1	Admission I	Date:	E	Expected Completion Date:						
specify below:			lf	admitted:	Weekly Tre	atment Hours:	A	dmission Counselor's Name:						
	(Specify LOC)		·				,							







Please return this form to the CENS via [Secure] FAX or email upon Admission, No Show, or Rescheduled Appointment.

Comments:

