Referral

Residential Options for Adolescents in Recovery (R.O.A.R.)

Date: **Applicant**: **DOB**: **Age**:

Location: **Insurance Info:**

Referral Source Name and Title: **County:**

Referral Phone:

Guardian Name: **Guardian Phone:**

DCFS involvement: ☐ YES ☐ NO

If yes, explain and list name and contact information of DCFS case worker:

Reason for the Client's Referral:

Substances used and history:

Alcohol:	☐ Never used	☐ Currently using	☐ Past use	____Age first used
Amphetamines (e.g. Adderall):	☐ Never used	☐ Currently using	☐ Past use	____Age first used
Anti-anxiety (e.g. Benzodiazepines):	☐ Never used	☐ Currently using	☐ Past use	____Age first used
Barbiturates:	☐ Never used	☐ Currently using	☐ Past use	____Age first used
Cocaine/crack:	☐ Never used	☐ Currently using	☐ Past use	____Age first used
Heroin/morphine:	☐ Never used	☐ Currently using	☐ Past use	Age first used
LSD/acid:	☐ Never used	☐ Currently using	☐ Past use	____Age first used
Marijuana/hash:	☐ Never used	☐ Currently using	☐ Past use	____Age first used
Methamphetamine/Crystal meth:	☐ Never used	☐ Currently using	☐ Past use	____Age first used
Opioids (e.g., Oxycontin, Codeine):	☐ Never used	☐ Currently using	☐ Past use	____Age first used
Other (specify):	☐ Never used	☐ Currently using	☐ Past use	____Age first used

Client's perception of substance use:

☐ Not a problem ☐ Unsure if problem ☐ Some problem

☐ Significant problem ☐ Severe problem ☐ Actively wants help

Medical/Physical Issues: ☐ Yes ☐ No

If yes, explain**:**

Special Needs: (such as learning and intellectual disabilities. Attach records if applicable) ☐ Yes ☐ No

If yes, explain:

Mental Health and Substance Use History:

List current Diagnoses:

List previous Diagnoses:

Current Counseling/Therapy services: ☐ Yes ☐ No

Current and Past Mental Health/Psychiatric/Substance Misuse Treatment History: (Include all outpatient treatment and any psychiatric hospitalization or residential treatment) Attach records, if applicable.

Treatment Provider	**Dates of Service**		**Reason for Treatment**	**Type of Treatment**	**Response**
	From	To			
	From	To			

Describe any difficulties with adjustment, cooperation, or relationships with previous programs/ providers:

Describe any past suicide attempts:

Current Medication Usage: (List all current medications and reasons for use. Include name of prescribing physician or clinic.)

Medication	Dosage	Purpose	Prescribed By

Past Medications Prescribed:

Medication	Dosage	Purpose	Prescribed By

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

- ☐ Quarrels
- ☐ Domestic Violence
- ☐ Family abuse alcohol/drugs
- ☐ Child Abuse
- ☐ Child Neglect
- ☐ Family worried about client's use

Please describe:

Violent Behavior and Risk of Danger to Others

- ☐ No current physical aggressiveness and no known history of aggression to persons or property
- ☐ Current, recent, or known history of aggressiveness

__Physically aggressive toward

__Persons

__Risk or history of causing moderate to significant injury or death

__Property

__Risk or history of causing moderate to significant damage or destruction of property

__Verbally aggressive

__Risk or history of verbally intimidating/threatening peers

__Risk or history of verbally intimidating/threatening adults/authority figures

Describe juvenile court history (attach court documentation,if available)**:**

Provide name and contact information of Juvenile Probation Officer (if applicable):

Please describe any history of inappropriate sexual behavior:

Ever charged with a sexual offense: ☐ YES ☐ NO

Please describe: