SUBSTANCE ABUSE
SCREENING REFERRAL FORM

Date _____

DSS Office _____ **MA No.** _____

Head of Household _____ **AU No.** _____

Applicant/Recipient Name _____ **SS No.** _____

Address _____ **Telephone No.** (_____) _____-_____

_____ Zip _____ .o **Drug Felon**

DOB _____ **MCO (if applicable)** _____

LDSS Case Manager _____ **Telephone No.** (_____) _____-_____

Addiction Specialist Completes

1. o Customer failed to appear for screening.
2. o Customer refused to be screened and/or assessed.
3. o Customer's screen was negative.
4. o Customer failed to sign 1176 when substance abuse screen was positive.
5. o Customer's screen was positive. (Forward Independence Plan to Addiction Specialist)
6. o Customer acknowledged a substance abuse problem. (Forward Independence Plan to AS)
7. o Customer referred for assessment/treatment to: _____ (Name of Provider) on _____ (Date)
8. o Customer failed to appear for referred assessment/treatment by _____ (Date)
9. o Customer currently in treatment at _____

   Verified by _____ (Contact person at provider) (_____) _____-_____ (Telephone No.) _____ (Date)
10. o Service Referral made on _____ (Date)
11. o Comments: _____

    _____

    _____

For persons convicted of a drug felony

12. o Referred for drug testing/assessment to _____ (Name of Provider) on _____ (Date)
13. o Results o Positive o Negative _____ (Date) o No Show

Addiction Specialist _____ **Telephone No.** (_____) _____-_____

DHR/FIA 1177 (Revised 10/05) Previous editions obsolete.

WHITE–Addictions Specialist Copy PINK– DSS Case Record Copy