

Referral Date:

Client Name:

Client Number:

Age:

Phone:

OK to Leave a Message? Yes No OK to identify ADAPT? Yes No

Admission Date:

Last Contact Date:

Counsellor:

Phone:

Does the client want to stop using alcohol and/or other substances? Yes No

Is the client currently in withdrawal or experiencing symptoms of withdrawal? Yes No

Does the client want help with regard to withdrawal? Yes No

Substance Use History

How long has the client been using substances?

Which substances have been used in the past 3 months? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Crack | <input type="checkbox"/> Psychoactive Drugs |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Ecstasy | <input type="checkbox"/> OTC Codeine |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Inhalants | <input type="checkbox"/> RX. Opioids |
| <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Cannabis | <input type="checkbox"/> Heroin/Opium | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Caffeine/Energy Drinks | <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Methadone | |

COMMENTS: (eg. client goals, history of involvement etc.)

Please list any additional referrals made to date:

Please enclose Catalyst Information Sheets, *DTCQ and *BASIS 32 (*if available)

Please fax referral to 905-847-8959