HALTON ALCOHOL, DRUG and GAMBLING
ASSESSMENT PREVENTION & TREATMENT SERVICES

CWMS
Client Referral Form

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)

☐ Alcohol
☐ Amphetamines
☐ Barbiturates
☐ Benzodiazepines
☐ Cannabis
☐ Caffeine/Energy Drinks
☐ Cocaine
☐ Crack
☐ Ecstasy
☐ Inhalants
☐ Hallucinogens
☐ Heroin/Opium
☐ Methamphetamines
☐ Methadone
☐ Psychoactive Drugs
☐ OTC Codeine
☐ RX. Opiods
☐ Steroids
☐ Tobacco
☐ Other: _____

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