



# CONNECTICUTRENAISSANCE

*Reclaim your life*

BOARD PRESIDENT  
ALECIA ANDREWS

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## Adult Substance Use Residential Treatment Universal Referral Form

Date of Referral: \_\_\_\_\_

### **Referral Source (check one):**

- Agency & Referring Clinician Name & contact info:
- DCF Office & Referring Office Name & contact info:
- Probation Office & Referring Office Name & contact info:
- Bail Commissioner (Court town): Name & contact info:
- Other (Specify): Name & contact info:
- Self: Name & contact info:

### **Demographics:**

- Name:
- Gender:
- Date of Birth:
- Address:
- City/State/Zip Code:
- Home/Cell Phone:
- Primary Language if not English:
- Conservator of person/finance:

### **Acute Intoxication/Withdrawal Potential**

What are the substance use problem(s): \_\_\_\_\_

History of Use in past 30 days: Please complete the chart below:

Substance	Date Last Use	Frequency

Any recent substance use inpatient/residential admissions (when/where): \_\_\_\_\_

History of Overdose/Administered Naloxone/Narcan within past 30 days? Y/N \_\_\_\_\_

**Biomedical Conditions**

Please list medical conditions/diagnoses: \_\_\_\_\_

Please list medications being taken currently (including MAT): \_\_\_\_\_

If prescribed Methadone, from which OTP? (for coordination of care) \_\_\_\_\_

Pregnant or could be pregnant? Y/N

Are any of the following applicable?

Difficulty Walking	Y/N	
Difficulty with stairs	Y/N	
Use Medical Devices	Y/N	If yes, please specify (e.g., CPAP, Nebulizer, Oxygen Tank, Walker/Wheelchair, Insulin Pump, continuous glucose monitor (CGM)): _____

**Emotional, Behavioral, Cognitive Conditions**

Please list psychiatric diagnoses or concerns: \_\_\_\_\_

Any recent psychiatric hospitalizations (when/where): \_\_\_\_\_

Have you noticed any changes in memory, thinking, or ability to focus that are affecting daily life?

Please specify: \_\_\_\_\_

**Next Steps / Aftercare**

Plan after completing program (e.g., home, friend’s house, shelter, sober living, longer term care):

\_\_\_\_\_

**Pregnant & Parenting Women (PPW) Referrals Only:**

Are you actively parenting a young child(ren), that you would like to possibly accompany you into a residential treatment program and/or are you looking for parenting support to be a component of your treatment?

Ages of children that might accompany you: \_\_\_\_\_

Do you have DCF Involvement? If so, what is the nature of DCF's involvement (i.e. reunification, transfer of guardianship, TPR)? \_\_\_\_\_

If reunification is the Department's goal, what is the estimated reunification timeline?  
\_\_\_\_\_

Approximate date child(ren) came into DCF care (if applicable): \_\_\_\_\_

Name and Contact Information for:

DCF Worker: \_\_\_\_\_

DCF Supervisor: \_\_\_\_\_

DCF area office: \_\_\_\_\_

To submit this form, please: [add agency/program specific instructions]