PhoenixCenter
Prevent • Treat • Recover

Priority Status

Pregnant

IV User

DSS OUTPATIENT REFERRAL FOR AOD SERVICES

Please complete one form for each family being referred for services.

Parent Needing Assessment: Date of Referral:____________________

Parent #1: ____ Contact Number:___________________

Parent #1: ____ Contact Number:___________________

Case Worker Name: ________________________________ Contact Number: __________________

Adult Assessments are offered on a walk-in basis **Monday thru Thursday at 8:15AM**. You can assign a specific date and time below. **For pregnant and/or IV users, call (864) 467-3737 to schedule an appointment with priority.**

Appointment Date: _________________________________

Please bring the following to your appointment: Photo ID, any medications you are currently taking, and Medicaid and/or Insurance card(s). Plan to stay for 2-3 hours to complete the assessment process.

REASONS FOR REFERRAL

REPORTED SUBSTANCES OF USE

Opiates (pain meds)	THC	Benzos (Valium, Xanax, etc.)
Methamphetamine	Cocaine	Alcohol
Amphetamine	Heroin	Other:______________________

Client's reported last date of use: _______________

DRUG TEST RESULTS (PLEASE ATTACH IF APPLICABLE)

Date: ____________ Hair Urine Negative Positive: __________________________

CHILDREN

Number of Children: _____________ Have the children been removed from the home? Yes No

Child: _________________________ DOB: _______ Child: ______________________ DOB: _______

Child: _________________________ DOB: _______ Child: ______________________ DOB: _______

*Please send completed form by **fax (864) 467-3948** or **email** dssreferral@phoenixcenter.org*