Phoenix Center
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 on **TUESDAY & THURSDAY at 8:30AM and 12:00PM**. 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: _____ Time: ☐ 8:30AM ☐ 12:00PM

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*