

**Confidential Client Information**

## SUD Referral and Tracking Form

**Section 1: Completed by Individual Requesting SUD Screening**

Requestor's Name:		Requestor's E-mail:	
Department/Agency:		Office Phone:	Fax:
Location Name and Address:			
Date of Referral:	Name of Client:		Client's Date of Birth:
Client's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (F to M) <input type="checkbox"/> Transgender (M to F) <input type="checkbox"/> Unknown		Is the Client Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client's phone number:
Client's email:		Case/Program Identifying #:	
Select Program(s) or Population(s) that best fits with the client:	<input type="checkbox"/> AB 109 <input type="checkbox"/> DCFS <input type="checkbox"/> Juvenile Probation <input type="checkbox"/> General Relief	<input type="checkbox"/> Mental Health <input type="checkbox"/> Family Solutions Center <input type="checkbox"/> MAMA's Neighborhood <input type="checkbox"/> CalWORKS	<input type="checkbox"/> Mainstream Services Interim Housing <input type="checkbox"/> Project Roomkey <input type="checkbox"/> Homeless Outreach / Encampments <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other, specify: _____

**Refer the client directly to the CENS counselor at assigned co-location if information is known. Otherwise you may refer the client to one of the CENS Area Office listed below.**

**CENS Providers and Sites**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> SPA 1: Tarzana Treatment Centers<br>(661) 726-2630 (Phone)<br>(661) 723-3211 (FAX)<br><input type="checkbox"/> Co-Located Site<br>Specify Facility name and Address:<br>_____                          | <input type="checkbox"/> SPA 3: Prototypes<br>(626) 444-0705 (Phone)<br>(626) 444-0710 (FAX)<br><input type="checkbox"/> Co-Located Site<br>Specify Facility Name and Address:<br>_____                       | <input type="checkbox"/> SPA 5: Didi Hirsch Mental Health Services<br>(310) 895-2300 (Phone)<br>(310) 895-2353 (FAX)<br><input type="checkbox"/> Co-Located Site<br>Specify Facility Name and Address:<br>_____ | <input type="checkbox"/> SPA 7: Los Angeles Centers for Alcohol and Drug Abuse<br>(562) 273-0462 (Phone)<br>(562-273)-0013 (FAX)<br><input type="checkbox"/> Co-Located Site<br>Specify Facility Name and Address:<br>_____ |
| <input type="checkbox"/> SPA 2: San Fernando Valley Community Mental Health Center<br>(818) 285-1900 (Phone)<br>(818) 285-1906 (FAX)<br><input type="checkbox"/> Co-Located Site<br>Specify Facility Name and Address:<br>_____ | <input type="checkbox"/> SPA 4: Homeless Health Care Los Angeles<br>(213) 744-0724 (Phone)<br>(213) 748-2432 (FAX)<br><input type="checkbox"/> Co-Located Site<br>Specify Facility name and Address:<br>_____ | <input type="checkbox"/> SPA 6: Special Service for Groups<br>(323) 948-0444 (Phone)<br>(323) 948-0443 (FAX)<br><input type="checkbox"/> Co-Located Site<br>Specify Facility Name and Address:<br>_____         | <input type="checkbox"/> SPA 8: Behavioral Health Services<br>(310) 973-2272 (Phone)<br>(310) 973-7813 (FAX)<br><input type="checkbox"/> Co-Located Site<br>Specify Facility Name and Address:<br>_____                     |

I agree to schedule an appointment at one of CENS site and show up to the referred treatment site for SUD assessment and treatment services determined by the CENS counselor.

Signed: \_\_\_\_\_  
Client

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
Referral Requestor

Date: \_\_\_\_\_



## Section 2: Completed by CENS counselor

Client has Medi-Cal or My Health LA: _____	<input type="checkbox"/> If yes, Medi-Cal or My Health LA #: _____	<input type="checkbox"/> If no, Application #: _____ Submitted on: _____	Client's Sage Member ID Number: _____ Sage Referral ID Number (auto generated in Sage) _____
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## SUD Screening Completed by CENS Counselor:

Date of Screening: _____	Screened by: _____	Phone: _____
CENS Agency: _____	Email: _____	

## For CENS Counselors only - SUD Screening Results

Based on the American Society of Addiction Medicine (ASAM) Triage Tool the CENS Counselor recommends the following Provisional Level of Care (LOC):

### SCREENED NEGATIVE OR EARLY INTERVENTION FOR TREATMENT

- SUD Treatment Not Recommended       ASAM Level 0.5: Early Intervention

#### ↳ WAS AT RISK EDUCATION WORKSHOPS PROVIDED?

- Yes       No

### SCREENED POSITIVE FOR OUTPATIENT TREATMENT

- ASAM Level 1.0: Outpatient Services  
 ASAM Level 2.1: Intensive Outpatient Services  
 ASAM Level 1-OTP: Opioid (Narcotic) Treatment Program  
 ASAM Level 1-WM: Ambulatory WM without Extended On-Site Monitoring

### SCREENED POSITIVE FOR RESIDENTIAL TREATMENT

- ASAM Level 3.1: Low-Intensity Residential Services  
 ASAM Level 3.3: High-Intensity Residential Services, Population-Specific  
 ASAM Level 3.5: High-Intensity Residential Services, Non-Population Specific  
 ASAM Level 3.2-WM: Clinically Managed Residential WM

### SCREENED POSITIVE FOR INPATIENT TREATMENT

- ASAM Level 3.7-WM: Medically Monitored Inpatient WM  
 ASAM Level 4-WM: Medically Managed Intensive Inpatient WM

### REFERRED TO OTHER SUPPORT SERVICES

- Recovery Support Services  
 Recovery Bridge Housing (requires concurrent enrollment in ASAM 1.0, 2.1, 1-OTP, or 1-WM)  
 Other (Specify): \_\_\_\_\_

**Client Referred to SUD Treatment:**  Yes     No     Refused  
**If Yes, complete the following information:**

Name of Treatment Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Email: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

**If client is referred to SUD treatment, please complete Release of Information (ROI) form**

[ROI – In Network Provider](#); [ROI – Out of Network](#)

**The Release of Information (ROI) form has been signed.**  Yes  No

## Section 3: Treatment Provider Must Complete this Section and Return to CENS

Client showed up to appointment: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, rescheduled to: _____ Date _____ Time _____	
If admitted LOC is different than the ASAM Co-Triage LOC, specify below: _____ (Specify LOC)	If admitted:	Admission Date: _____ Weekly Treatment Hours: _____
		Expected Completion Date: _____ Admission Counselor's Name: _____

Please return this form to the CENS via [Secure] FAX or email upon Admission, No Show, or Rescheduled Appointment.

Comments: