Phoenix Houses OF CALIFORNIA

Adult Outpatient Substance Use Disorder Referral Form

Date of referral: _____ Service location: ◯ Santa Ana ◯ Venice Beach ◯ Lake View Terrace

Name of client: _____ Date of birth: _____ Age: _____

Insurance type: ◯ Medi-Cal ◯ Private ◯ No insurance

Medi-Cal No. _____

Insurance provider name: _____ Card No. _____

Name of legal guardian/conservator, if applicable: Preferred language: _____

_____

Telephone No. _____ Address 1: _____

Address 2: _____

If the client is under conservatorship, is the legal guardian/conservator aware of the referral? ◯ Yes ◯ No

If not, please make sure to discuss with legal guardian/conservator before submitting referral.

Referring Party

Name of referring party: _____ Title: _____

Agency: _____ Contact No. _____

You will be contacted to confirm receipt of this referral.

Substance Using Or Suspected

◯ Marijuana/Cannabis ◯ Opioids (Heroin) ◯ Over-the-Counter
◯ Alcohol ◯ Hallucinogens (Shrooms, LSD) ◯ Other _____
◯ Cocaine ◯ Amphetamines (Meth) ◯ Unknown

Additional Information

How long have they been, or suspected of, using the substance indicated above? _____

_____

Involvement with: ◯ DCFS ◯ Probation ◯ N/A

How did you hear about us? _____

Submit to Lake View Terrace | Submit to Santa Ana | Submit to Venice Beach

Office Use Only

Administrative Use: ◯ MC/INS ◯ WG ◯ Intake ◯ RO

Intake date: _____ Comments: _____

_____

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