2nd Chance
1541 SE Port St. Lucie Boulevard, Suite F
Port Saint Lucie, FL 34952
Phone: (772) 335-0166
Fax: (772) 335-0169

SUBSTANCE ABUSE & MENTAL HEALTH SERVICES REFERRAL FORM

PLEASE COMPLETE THIS FORM IN FULL BEFORE FAXING

☐ **Mental Health**
- Diagnosed hx of MI

☐ **Substance misuse**
- Use less than a year ago

☐ **Co-occurring disorder**
- Recent hx of substance misuse
- Hx of diagnosis of MI

Client's First Name: _____ Last Name: _____

Address: _____

Phone #_____ D.O.B._____ Male ☐ Female ☐

1. Reason for Referral? (Please describe current symptoms and behaviors)
   _____
2. Substance Abuse and Alcohol history:
   _____
3. Referral Source Name: _____ Phone: _____

   Address:_____
4. Are you involved with the legal system:____ YES ____ NO
   □ Marchman Act □ Arrest □ Parole □ Probation

   If so, what are the charges: _____

   □ P.O. Name:_____ P.O. Phone #:_____
5. Did the court or DCF order you to a program:____ YES ____ NO (If YES attach copy) Which program:_____
6. Have you been in counseling before: ____ YES ____ NO If YES, when:_____ Where:_____

   Reason: _____
7. Diagnosis: _____
8. Current Medications: _____
9. Insurance information:_____
10. Psychiatrist's Name and phone: (if any):_____
11. Case Manager's name and phone (if any):_____
12. Can a confidential message be left on the client's voicemail? Yes ☐ No ☐

Taken by **Date**