



2nd Chance
1541 SE Port St. Lucie Boulevard, Suite F
Port Saint Lucie, FL 34952
Phone: (772) 335-0166
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SUBSTANCE ABUSE & MENTAL HEALTH SERVICES REFERRAL FORM

PLEASE COMPLETE THIS FORM IN FULL BEFORE FAXING

- Mental Health** **Substance misuse** **Co-occurring disorder**
- Diagnosed hx of MI
 - Use less than a year ago
 - Recent hx of substance misuse
 - Hx of diagnosis of MI

Client's First Name: _____ Last Name: _____

Address: _____

Phone # _____ D.O.B. _____ SSN _____ 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