the Centers
717 SW MLK Jr. Ave. Ocala, FL 34474
(352) 351-6967
Children's Substance Abuse Outpatient Program
Referral Form

Referral Date: _____ Referred by: _____DCF #_____

Client Name: _____ Sex: M/F MIS: _____

Parent's/Guardian's Name: _____Daytime phone:_____

Client's DOB: _____ Age: ____ Social Security #: _____

Insurance Provider: Medicaid #: _____ other: _____

Home Address: _____

City: _____, ST: _____ Zip Code: _____

Presenting Problem:
_____

Brief history of Drug and/or Alcohol use: _____

_____

Appointment date: _____Time: _____ Counselor: _____

Client Signature: _____ Referral Signature: _____
****

Screening (to be completed by CSAOP counselor**)**

Date referral was received: _____ Date of contact w/ client: _____

Client's Treatment Status:
Appropriate for admit into CSAOP program _____

Inappropriate for CSAOP program _____ Explain: _____

Client Signature**:** _____ Counselor signature**:** _____

CLIENT REFUSED TREATMENT: _____ Why: _____

Client's Signatur**e:** _____ Counselor's Signature**:** _____