INTEGRATIVE
THERAPEUTIC SOLUTIONS, LLC.

Substance Use Disorder Referral Form

Referral Date: ___ / ___ / _____

SECTION A: Client Information

Full Name: _____

Date of Birth: ___ / ___ / _____

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Other: _____

Phone Number: (_____) _____ – _____

Email Address: _____

Address: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Primary Insurance: _____

Policy/ID #: _____

Emergency Contact Name: _____

Emergency Contact Phone: (_____) _____ – _____

3200 Crain Highway Ste. 205
Waldorf, MD 20603
Phone: (240) 448-2475
Fax: (240) 448-2335

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SECTION B: Referral Source

Name of Referring Provider/Agency: _____

Phone Number: (_____) _____ – _____

Fax Number: (_____) _____ – _____

Email: _____

Relationship to Client: ☐ Primary Care ☐ Mental Health Provider
☐ Court/Parole ☐ School ☐ Self ☐ Other: _____

SECTION C: Reason for Referral

(Check all that apply)
☐ Assessment for substance use concerns
☐ Detoxification services
☐ Outpatient treatment
☐ Intensive outpatient treatment (IOP)
☐ Residential treatment
☐ Medication-Assisted Treatment (MAT)
☐ Dual diagnosis evaluation
☐ Court-ordered treatment
☐ Relapse prevention
☐ Peer support or recovery coaching
☐ Other: _____

SECTION D: Presenting Concerns

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Substance(s) Used: _____
Approximate Date of Last Use: ___ / ___ / _____
Frequency: _____
Mode of Use (e.g., oral, inhalation, IV): _____
History of Withdrawal Symptoms: ☐ Yes ☐ No
If yes, please describe: _____

Mental Health/ Substance Use Diagnoses (if any): _____
Current Medications: _____

Is the client currently in treatment elsewhere? ☐ *Yes* ☐ *No*
If yes, where: _____

SECTION E: Risk Factors (Check any that apply)

☐ Homeless or unstable housing
☐ Unemployment
☐ Legal involvement
☐ Pregnant
☐ Co-occurring mental health diagnosis
☐ Prior overdose(s)
☐ Recent hospitalization
☐ History of trauma/abuse
☐ Suicidal ideation
☐ Other: _____

SECTION F: Supporting Documents Attached

☐ Assessment Summary
☐ Diagnosis (ICD-10)

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☐ Recent Labs
☐ Treatment History
☐ Court Order
☐ Consent for Release of Information
☐ Other: _____

SECTION G: Referral Consent

☐ **Client has provided written or verbal consent to be referred for substance use disorder services.**

Signature of Referring Provider: _____
Date: ___ / ___ / _____

Receiving Agency Use Only:

Date Received: ___ / ___ / _____

Referral Accepted: ☐ Yes ☐ No

Program Referred To: _____

Scheduled Intake Date: ___ / ___ / _____

Assigned Clinician/Case Manager: _____

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