Referral Form
Drug Abuse Treatment Association (DATA)

Client Name: _____ **DOB:** _____ **Date of Referral:** _____

Parent/Guardian Name: _____ **Phone:** _____

Client/Family Address: _____

Client Legal Status: ☐ Juvenile Justice ☐ Marchman Act ☐ Child Welfare ☐ Voluntary ☐ Other: _____

School: _____ **Last Grade Completed:** ____ **Classes:** ☐ Regular ☐ Special

Past Substance Use Treatment: ☐ Outpatient ☐ Residential ☐ None Reported **Dx:** _____

Past Mental Health Treatment: ☐ Outpatient ☐ Residential ☐ None Reported **Dx:** _____

Medical Conditions: _____

Need for Auxiliary Aids: ☐ Deaf/Hard of Hearing ☐ Limited English Proficiency ☐ Other: _____ ☐ None

Priority Population: ☐ IV Drug Use ☐ Pregnant ☐ HIV/AIDS ☐ TB

Reason for Referral: _____

Referred By: _____ **Title:** _____

Referent Phone Number: _____ **Referent E-mail:** _____

Referent Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Comments:

_____ _____
Referent Signature **Date**

Please attach any supporting documentation that may assist with evaluating this client and fax to the Attention of the Director of Treatment at 561.845.0316 (West Palm Beach office) or 772.595.3704 (Fort Pierce office).

DATA
Behavioral Health Services
for Children and Families

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