Self-Referral to Substance Use Disorder Treatment Services

Thank you for your interest in substance use treatment. Please complete the following information and return the form to the designated custody staff so they can link you with a treatment screening appointment.

PERSONAL INFORMATION

First Name: _____ M.I. ___ Last Name: _____ Age: _____

Phone Number: (____) _____ OK to leave message? ☐ YES ☐ NO Preferred Language: _____

Do you have a place to live when released from custody: ☐ YES ☐ NO

Address:_____
Street City State Zip Code

Gender Identity: ☐ Female ☐ Male ☐ Transgender (M to F) ☐ Transgender (F to M)
☐ Questioning/Unsure ☐ Other _____ ☐ Decline to state

Are you pregnant? ☐ YES ☐ NO Due Date: _____ # of Children under 18: _____

Ages of children: _____ Are the children in your custody? ☐ YES ☐ NO

Will the child(ren) be residing with you if you attend Residential Substance Use treatment? ☐ YES ☐ NO

Are you currently involved with CWS (Child Welfare Services)? ☐ YES ☐ NO

Do you have Medi-Cal? ☐ YES ☐ NO Do you have other Health insurance? ☐ YES ☐ NO

Insurance: _____

Do you have a source of income? ☐ YES ☐ NO

If so, type (ex. Employment, CalWORKs, Cash Aid, etc.) _____ Monthly Income: _____

Are you currently taking prescription medications for any medical conditions, including mental health? ☐ YES ☐ NO

If yes, please list medication and reason for prescription:

_____

Are there any medications that you should be taking but are not? ☐ YES ☐ NO

If yes, please list medication and reason for prescription:

_____

Do you have a mental health diagnosis? ☐ YES ☐ NO

If yes, please list: _____

Are you on Medically Assisted Treatment (MAT) (i.e., Methadone, Vivitrol/Naltrexone, Suboxone)? ☐ YES ☐ NO

Do you have any physical limitations or require ADA accommodations? ☐ YES ☐ NO

If yes, please describe: _____

ALCOHOL AND/OR OTHER DRUG USE (PRIOR TO INCARCERATION)

Primary Drug	# of Days used in past 30 days	Route of Admission	Age at first use	Date Last Used
Secondary Drug	**# of Days used in past 30 days**	**Route of Admission**	**Age at first use**	**Date Last Used**

Have you used needles in the past 12 months? ☐ YES ☐ NO ☐ Decline to state/NA If yes, last used: ___/____/____

Date you last used any drugs including alcohol: ____/____/____ Number of days in a row you had been using: _____

How long do you think you have had a problem with alcohol and/or other drugs? _____

Have you received treatment for alcohol and/or other drugs in the past? ☐ YES ☐ NO
If yes, please give details:

Type of Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Treatment Facility	Dates of Treatment	Treatment Completed (yes or no)

How long have you currently been in custody? _____

Have you ever been arrested/charged/convicted/registered for arson? ☐ YES ☐ NO

Have you ever been arrested/charged/convicted/registered for a sex crime(s)? ☐ YES ☐ NO

Comments: _____

_____

_____

If additional resources or information is needed, please contact the San Diego Access & Crisis Line (ACL) at **1-888-724-7240**. ACL staff is available to answer questions 24 hours a day, 7 days a week.

Clients receiving services through County of San Diego contracted SUD programs are treated with equality, in a welcoming, nondiscriminatory manner, consistent with applicable state and federal law. County of San Diego contracted SUD programs serve those that are at or below 200% of the Federal Poverty Level. Client fees are waived for Medi-Cal eligible persons participating in Medi-Cal certified services (except for required Medi-Cal share of cost). No services will be refused due to a client's inability to pay.