AGS PROGRAMS, LLC
"Achieving Your Greatest Self"

Referral for Services SUD IOP/OP(May2021)

Returning Consumer: ☐ Yes ☐ No **Date: _____**

Consumer Information ONLY

Consumer Name:	Date of Birth:
SS#:	MA#:
Gender Assigned at Birth:	Gender Identity:
Sexual Orientation:	Phone Number:
Message OK?	Email Address:
Living Situation:	Address:
City:	State/Zip code:
School/Grade (if applicable):	Address of School:
Preferred Method of Contact:	Best Time to Call:
Are you Employed?	If yes, ☐ Supportive Employment ☐ PT ☐ FT

Referral Source Information

Name:	Agency (if applicable):
Phone Number:	Fax Number:
Email Address:	Relationship to Consumer:

Parent/Guardian Information:

Name of Parent/Guardian:	Relationship:
Address:	Contact Number:

A LEGAL DOCUMENT MUST BE PRESENTED TO SHOW GUARDIANSHIP
COURT ORDER/LEGAL DOCUMENTATION

Please answer the following:

Is the consumer of Hispanic, Latino, or Spanish origin?	
Race:	

How well does the consumer speak English?	
Does the consumer speak another language other than English at home?	
If Yes, what is the language?	
Number of arrests in the past 30 days?	
Is the consumer deaf or do they have hearing difficulty?	
Is the consumer blind or do they have serious difficulty seeing, even when they wear glasses?	

REASON FOR REFERRAL/Primary Concerns:

SUBSTANCES USE:

Type of Substance	Age at First Use	Route of Transmission	Frequency of Use	Date of Last Use

Currently Receiving Medication Assisted Treatment? ☐ Yes ☐ No	Clinic Name/Phone Number of MAT:
Mental Health Diagnosis:	Current Therapy/Treatment Supports: