



BLAIR DRUG AND ALCOHOL PARTNERSHIPS DRUG AND ALCOHOL RC/ICM CASE MANAGEMENT REFERRAL FORM

RC/ICM services assist eligible persons in gaining access to the non-treatment resources that they need. RC/ICM services are provided to eligible individuals at no cost. Refusal to participate **will not** jeopardize your drug and alcohol treatment.

If you are interested, a case manager will contact you to set up an initial meeting. If you are in partial, intensive outpatient or outpatient, the contact will occur within seven days. If you are discharged from a detox or inpatient facility, the contact will occur within five days.

_____ **I am willing to meet with the case manager** _____ **I am not interested in this service at this time**

Individual: Signature / DATE _____

WITNESS: Please Print Name / DATE _____

 Person/Agency making referral: _____

Client Name: _____

D.O.B: _____

Address: _____

Age: _____

MA ID#: _____

Phone: _____

SS#: _____

Other Involved Agencies: _____

Is the client currently pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the client have children in their custody?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the client an IDU?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the client a survivor of overdose? If yes, date of overdose:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is client currently incarcerated? If yes, scheduled release date:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is client currently in an inpatient facility (drug and alcohol or mental health)? If yes, scheduled date of discharge:	Yes <input type="checkbox"/> No <input type="checkbox"/>

Diagnosis

Axis I: _____ Axis II: _____

Additional Comments: _____

Office Use Only:

Date Assigned: _____

Case Manager: _____

Date Opened: _____