DISC VILLAGE

OUTPATIENT REFERRAL FORM

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

Client Email: _____ **Client Phone:** _____

Referral Name *(i.e. PO, Case Worker)*: _____

Referral Email: _____ **Referral Phone:** _____

Part 1: Priority Population

Answer all the following:

Are you/the client pregnant or postpartum (had a baby within past year)? ☐ Yes + ☐ No

Are you/the client currently using opiates? *(Heroin, Methadone, Oxycodone, prescription pain medicine, Suboxone/Buprenorphine, etc.)*

☐ Yes ^ ☐ No

Are you/the client using drugs intravenously (IV drugs)? ☐ Yes + ☐ No

Have you/the client experienced an overdose within the last year? ☐ Yes ^ ☐ No

Do you/the client have Medicaid? ☐ Yes ☐ No #

If 'Yes', have you/the client used substances within the past 30 days? ☐ Yes ^ ☐ No #

Do you/the client have other insurance coverage? ☐ Yes ☐ No If 'Yes', name of health plan: _____

DISC Staff: ***+ - 48 hours*** ***^ - 7 calendar days*** ***# - 14 calendar days***

Part 2: Referral Information

REFERRAL SOURCE: (Who referred you here today?)

- ☐ Self-Referral
- ☐ DCF/Camelot/Child Welfare
- ☐ Circuit/State Probation (DOC)
- ☐ Federal Probation (USPO)
- ☐ North Florida DUI Programs/DUI School
- ☐ Pre-Trial
- ☐ County Probation: _____
- ☐ Drug Court
- ☐ Physician/Counselor
- ☐ Apalachee Center
- ☐ Dept. of Juvenile Justice
- ☐ Other: _____

REASON FOR REFERRAL (Check all that apply – Adults must have substance use checked)**:**

- ☐ Substance Use
- ☐ Suicidal Ideation
- ☐ Poor Communication
- ☐ Grief
- ☐ Anxiety
- ☐ Self-Esteem
- ☐ Poor Decision-Making Skills
- ☐ Emotion Regulation
- ☐ Trauma
- ☐ Anger Management
- ☐ Depression
- ☐ Family
- ☐ Behavioral Issues
- ☐ Other: _____

REQUESTED SERVICES: (Referring Agency Only)

If referring for specific services, please indicate below. Mark all that apply.

- ☐ Assessment & Recommendation
- ☐ Counseling (Type: ☐ Substance Use ☐ Mental Health [youth only])
- ☐ Juvenile Drug Court
- ☐ Other: _____

MIS #: *(staff use)*:_____

COLLATERAL INFORMATION: (Referring Agency Only)

Please attached relevant information to this referral from and indicate below:

☐ Legal Charges	☐ Court Order	☐ Psychiatric/Medical Information
☐ Arrest Affidavit	☐ Disposition Order	☐ Expanded Facesheet
☐ PACT	☐ GAIN-Q	☐ State Attorney Recommendation (Non-Judicial)
☐ Case Plan	☐ Shelter Order	☐ Other: _____

Is the client receiving any other counseling services? ☐ Yes ☐ No

If yes, where and by whom? _____

Is the client receiving any other community-based services? ☐ Yes ☐ No

If yes, where and by whom? _____

ADDITIONAL REFERRAL COMMENTS: (Referring Agency Only)

_____

_____

SELECT SERVICE LOCATION:

☐ **Leon County Outpatient Services (Adult & Youth)**
1000 W. Tharpe St., Suite 14
Tallahassee, FL 32303
Office: 850) 561-0717
FAX: (850) 414-6876
Email:
Leoncountyreferrals@discvillage.org

☐ **Madison County Outpatient Services (Adult & Youth)**
(Accepts Jefferson County)
Address:1476 SW Main St.
Greenville, FL 32331
Office: (850) 948-1231
FAX: (850) 948-1230
Email:
Madisoncountyreferrals@discvillage.org

☐ **Wakulla County Outpatient Services (Adult & Youth)**
85 High Dr.
Crawfordville, Florida 32326
Office: (850) 926-2452
FAX: (850) 926-8355
Email:
Wakullacountyreferrals@discvillage.org

☐ **Gadsden County Outpatient Services (Adult & Youth)**
(Accepts Liberty County)
305 W. Crawford St., Suite 1
Quincy, Florida 32351
Office: (850) 627-3599
FAX: (850) 875-2938
Email:
Gadsdencountyreferrals@discvillage.org

☐ **Taylor County Outpatient Services (Adult & Youth)**
1012 South Jefferson St.
Perry, Florida 32348
Office: (850) 223-1003
FAX: (850) 223-0223
Email:
Taylorcountyreferrals@discvillage.org

☐ **Franklin County Outpatient Services (Adult & Youth)**
150 10th St.
Apalachicola, Florida 32320
Office: (850) 653-1200
FAX: (850) 653-1202
Email:
Franklincountyreferrals@discvillage.org

Please submit form to the specific service location via any of the methods listed above (email, fax, physical location).

OFFICE USE ONLY
Date Received: _____ Logged in Referral Log? ☐ Yes ☐ No
Received By: _____