TRI-COUNTY COMMISSION ON ALCOHOL AND DRUG ABUSE/DAWN CENTER
REFERRAL FOR AOD SERVICES

DATE OF REFERRAL: _____

NAME: _____ DOB: _____

RACE _____ SS# _____

RELATIONSHIP STATUS: MARRIED / SINGLE / DIVORCED/ SEPARATED / WIDOWED / NEVER MARRIED

IF FEMALE, IS SHE PREGNANT? YES ____ NO ____ DOES CLIENT USE T0BACCO/VAPE? YES ___ NO ___

IS THE CLIENT AN IV DRUG USER? YES _____ NO _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ CELL NUMBER: _____

EMPLOYED? YES ____ NO ____ WHERE? _____ FULL / PART-TIME

INSURANCE: _____ POLICY NUMBER: _____

MEDICAID ID NUMBER: _____

REASON FOR REFERRAL: _____

_____

_____

_____

_____

_____

_____

KNOWN PSYCHIATRIC ISSUES: _____

_____

MEDICATIONS: _____

_____

REFERRAL AGENT: _____

PHONE: _____ E-MAIL ADDRESS: _____

SEND COMPLETED FORM TO: Tri-County Commission on Alcohol and Drug Abuse Fax: **(803) 536-4980**
Orangeburg 803 536-4900 ext. 126 or 132 Santee Office - 803 854-7049 ext. 190