REQUEST FOR SERVICE FORM

RETURN TO EMAIL transitionalcare@tcssap.com

Date _____

First Name _____ Last Name_____

Client Status _____

Current Address _____

Address Line 2 _____
City _____ State _____ Zip Code _____

Country of Residence_____

Home Phone _____ Cell Phone_____

Work Phone _____ Email_____

Race _____ Gender_____

Marital Status _____ Language Spoken_____
Employment Status _____ S.S.I.#_____

Date of Birth _____ Spirituality_____

Insurance Coverage? ☐ YES ☐NO Is Substance Abuse (SA) covered under your Insurance? ☐ YES ☐ NO

Insurance Coverage: _____

Member ID/Policy #_____ Group#_____

Referring Program: ☐ OMHC ☐ EAP ☐ Substance Abuse

Referral Source _____ Referred By_____

Reason for Referral_____
Priority for Service ☐ HIGH ☐ LOW

Primary Caretaker _____ Is Primary Caretaker Address same as Child? ☐ YES ☐ NO

Address if different from Client _____

Court Ordered? ☐ YES ☐ NO If YES, note Court and P.O. Name _____

Any Legal Involvement? _____
_____

Number of Arrests in the Past 30 Days _____

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SCHOOL INFORMATION

School Name _____

School Street Address _____

Address Line 2 _____

City _____ State_____ Zip Code _____

School Phone _____ School Fax _____

Grade / Highest Level Complete_____ Special Education Level _____

School Therapist (if any) _____

CLINICAL INFORMATION

Have you received any prior Substance Abuse Treatment? ☐ YES ☐ NO

Opiate and other Substance Abuse History (Current and Past Addiction / Abuse of alcohol, prescription drugs, or illegal drugs and treatment history):

_____

_____

Have you received any Previous Hospitalizations / Residential Placements? ☐ YES ☐ NO

If YES, where? _____Date(s)_____

Have you received Previous Therapy / Medication Management Services? ☐ YES ☐ NO

What Medications are you currently taking?

MEDICATION START DATE SIG QUANTITY PROVIDER PHARMACY REFILLS

_____

_____

_____

_____

_____