**Substance Use Disorder Professional (SUDP) Referral**

dcyfsudpreferrals@dcyf.wa.gov Date 0f Referral:

Client information

|  |  |  |
| --- | --- | --- |
| Name:       | FAMLINK Person ID:      | DOB:      |
| Phone:       | Email:       | Address:      |
| Caregiver information, if applicable:       | Insurance Coverage:       |
| Case Name:       | FAMLINK Case ID #      | Drop down, CPS, FAR, legally free |
|  |  |  |

Additional information Service request:

DCYF Caseworker information

|  |  |  |
| --- | --- | --- |
| Caseworker:      | Email:      | Phone:      |
|  Supervisor:      | Email:      | Phone:      |

Services needed: To be filled out by SUDP

Complete Drug and Alcohol assessment [ ]  Reason:

|  |  |  |
| --- | --- | --- |
| [ ]  Collaboration | [ ]  Provider Engagement | [ ] Case management  |
| [ ]  (SBIRT)Screening, Brief Interventions & Treatment | [ ]  Attend Case staffing | [ ]  Meet with client |
| [ ]  American Society of Addiction Medicine (ASAM) | [ ]  Education on Prevention | [ ]  Meet with client’s supports, ie identified family. |
| [ ]  (MOUD)Medications for Opioid use Disorder | [ ]  Develop relapse prevention with client. | [ ]  Meet with SUD agencies to connect client with services.  |
| [ ]  (UNCOPE)Used, Neglected, Cut Down, Objected Preoccupied, Emotional Discomfort | [ ]  Household, family member screen for SUD services, if needed. | [ ]  Facilitate appropriate Release of information/Consents |
| [ ]  Collaboration with caseworker on client progress and needed supports. | [ ]  Connections to community providers | [ ]  Appointment for Assessment & rescheduling when missed. |

Additional Assistance/Comments

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |       |  |       |
| Social Worker Signature |  | Print Name |  | Date |

Please contact James Vallembois, SUD Program manager, james.vallembois@DCYF.wa.gov with any questions.