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www.SBCounty.gov

SAN BERNARDINO COUNTY

Department of Behavioral Health
Substance Use Disorder and Recovery Services

Reset

Substance Use Disorder Referral

SUD Treatment Provider:

- Determine the next appropriate level of care for the client (If Residential Treatment or Withdrawal Management are indicated, follow established Screening Assessment and Referral Center (SARC) procedures).
- Utilizing the DBH-SUDRS Organizational/Rendering Provider Directory, review with the client to determine which provider and location will best suit their needs.
- As the referring agency complete the Authorization for Release of Protected Information (COM001) and secure the intake appointment at the next level of care for the client.
- Forward the completed referral along with the Authorization for Release of Protected Health Information to the respective agency within 24 hours of the client's discharge services.
- Provide the completed referral form and copy of Authorization for Release of Protected Health Information to the client and retain a copy of the referral form and the original Release of Protected Health Information in the client's record.

Name of Client **DOB** **Client #**

Address **Phone #**

Referring Agency **SUD Treatment Completion Date**

Referring Agency Phone Number **Today's Date**

You have been referred to: *(Choose service type; insert the appointment date/time, provider name, address, and phone number)*

- ☐ Adult Intensive Outpatient Treatment (IOT)
- ☐ Perinatal Outpatient Treatment
- ☐ Youth Outpatient Treatment
- ☐ Recovery Center for support in your recovery
- ☐ Narcotic Treatment Program (NTP)
- ☐ Youth Intensive Outpatient Treatment (IOT)
- ☐ Adult Outpatient Treatment
- ☐ Recovery Services at a Recovery Center
- ☐ Care Coordination
- ☐ Medication Assisted Treatment (MAT)

Name of Provider: _____

☐ Kick It California (tobacco cessation): https://kickitca.org/health-professionals

Date of Appointment **Appointment Time**

SUD Treatment Provider Name

Address

City **Phone #**

NOTE*: Authorization for Release of Protected Health Information (COM001) must be completed by client and faxed with this referral to the Substance Use Disorder treatment provider.*

TO BE COMPLETED BY REFERRING PROVIDER

SUD Treatment Center:	
Address:	
Phone Number:	
Appointment Date:	Time:

Comments: