SHORES Drug and Alcohol Outpatient Program

Referral Screening Form

Email form to: shoresreferrals@hfi-pgh.org

Referral Date: _____ ☐ Do NOT call Parents/Guardians (check if applicable)

Client Name: _____ County: _____

Client Address: _____ Zip Code: _____

Client Email Address: _____ ☐ Male ☐ Female

Cell #: _____ Home #: _____

Date of Birth: _____ Age: _____ SS#: _____

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Contact Person to set up Eval:_____ Relationship: _____

Phone#: _____ Email Address: _____

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Emergency Contact Name: _____ Relationship: _____ Phone #: _____

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Primary Insurance Name: _____ Name of Insured: _____

Policy ID #: _____ Group #: _____

Secondary Insurance Name: _____ Name of Insured: _____

Policy ID #: _____ Group #: _____

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Drug of Choice: _____ Route of Administration: _____

Pattern of Use: _____

Court Ordered? ☐ No ☐ Yes ***(if yes, please fax copy of court order to 412-732-7409)***

Does the client attend school? ☐ No ☐ Yes ***(if yes, what school?)*** _____

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Priority Population:

☐ Currently Pregnant IV Drug User ☐ Currently Pregnant Substance User

☐ IV Drug User ☐ Overdose Survivor ☐ Veteran ☐ Not Applicable

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Referral Source Please Complete

Name: _____ Phone #: _____Fax #: _____

Agency: _____ Email: _____

If this is your first time referring, how did you find out about our program?

☐ Co-worker ☐ Client ☐ TV/Radio ☐ Other, please specify: _____

SHORES Program, Holy Family Institute, 8235 Ohio River Blvd, Pittsburgh, PA 15202

Phone: 412-766-9020 x 1474 Fax: 412-732-7409