Better Path COC Referral & Preliminary Screening Form

Referral Partner: _____

Date of Referral: _____

Client Information

- Full Name: _____
- Date of Birth:_____
- SSN or MA#:_____
- Phone Number:_____
- Emergency Contact:_____

Clinical Information

- Primary Substance(s) Used:_____
- Date/Time of Last Use:_____
- Current Mental Health Diagnoses (if known): _____
- Current Medications:_____
- History of Detox/Treatment: _____

Program Needs

☐ Housing Needed

☐ Transportation Needed

☐ PHP

☐ IOP

☐ Unsure/Needs Assessment

Intake Readiness

☐ Client is alert and oriented.

☐ Client is able to complete paperwork independently.

☐ Client may require verbal assistance with intake.

☐ Client is not actively under the influence to the extent that participation is impaired.

Is this Court Ordered? _____ No | _____ Yes, if so Probation Officer Name_____

Is the client presenting any Suicidal or Homicidal ideations? ____Yes | ____ No
Are there any Medical Concerns that we should be aware of? ____No | ____ Yes, if so what are those concerns?_____

Referral Partner you can now fax or email this form to us.