CENS
Client Engagement and Navigation Services

Confidential Client Information

SUD Referral and Tracking Form

Section 1: Completed by Individual Requesting SUD Screening

Requestor's Name:	Requestor's E-mail:	
Department/Agency:	Office Phone:	Fax:
Location Name and Address:		
Date of Referral:	Name of Client:	Client's Date of Birth:
Client's Gender: ☐ Male ☐ Female ☐ Transgender (F to M) ☐ Transgender (M to F) ☐ Unknown	Is the Client Pregnant: ☐ Yes ☐ No	Client's phone number:
Client's email:	Case/Program Identifying #:	

Select Program(s) or Population(s) that best fits with the client:	☐ AB 109 ☐ DCFS ☐ Juvenile Probation ☐ General Relief	☐ Mental Health ☐ Family Solutions Center ☐ MAMA's Neighborhood ☐ CalWORKS	☐ Mainstream Services Interim Housing ☐ Project Roomkey ☐ Homeless Outreach / Encampments ☐ Permanent Supportive Housing	☐ Other, specify: _____

Refer the client directly to the CENS counselor at assigned co-location if information is known. Otherwise you may refer the client to one of the CENS Area Office listed below.

CENS Providers and Sites

☐ SPA 1: Tarzana Treatment Centers
(661) 726-2630 (Phone)
(661) 723-3211 (FAX)
☐ Co-Located Site
Specify Facility name and Address:
_____

☐ SPA 3: Prototypes
(626) 444-0705 (Phone)
(626) 444-0710 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 5: Didi Hirsch Mental Health Services
(310) 895-2300 (Phone)
(310) 895-2353 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 7: Los Angeles Centers for Alcohol and Drug Abuse
(562) 273-0462 (Phone)
(562-273)-0013 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 2: San Fernando Valley Community Mental Health Center
(818) 285-1900 (Phone)
(818) 285-1906 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 4: Homeless Health Care Los Angeles
(213) 744-0724 (Phone)
(213) 748-2432 (FAX)
☐ Co-Located Site
Specify Facility name and Address:
_____

☐ SPA 6: Special Service for Groups
(323) 948-0444 (Phone)
(323) 948-0443 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 8: Behavioral Health Services
(310) 973-2272 (Phone)
(310) 973-7813 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

I agree to schedule an appointment at one of CENS site and show up to the referred treatment site for SUD assessment and treatment services determined by the CENS counselor.

Signed: _____ Date: _____
Client

Signed: _____ Date: _____
Referral Requestor

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Section 2: Completed by CENS counselor

Client has Medi-Cal or My Health LA:	☐ If yes, Medi-Cal or My Health LA #: _____	☐ If no, Application #: _____ Submitted on: _____	Client's Sage Member ID Number: _____ Sage Referral ID Number *(auto generated in Sage)* _____

SUD Screening Completed by CENS Counselor:

Date of Screening:		Screened by:		Phone:
CENS Agency:			Email:	

For CENS Counselors only - SUD Screening Results

Based on the American Society of Addiction Medicine (ASAM) Triage Tool the CENS Counselor recommends the following Provisional Level of Care (LOC):

SCREENED NEGATIVE OR EARLY INTERVENTION FOR TREATMENT

☐ SUD Treatment Not Recommended ☐ ASAM Level 0.5: Early Intervention

➥ **WAS AT RISK EDUCATION WORKSHOPS PROVIDED?**

☐ Yes ☐ No

SCREENED POSITIVE FOR OUTPATIENT TREATMENT

☐ ASAM Level 1.0: Outpatient Services

☐ ASAM Level 2.1: Intensive Outpatient Services

☐ ASAM Level 1-OTP: Opioid (Narcotic) Treatment Program

☐ ASAM Level 1-WM: Ambulatory WM without Extended On-Site Monitoring

SCREENED POSITIVE FOR RESIDENTIAL TREATMENT

☐ ASAM Level 3.1: Low-Intensity Residential Services

☐ ASAM Level 3.3: High-Intensity Residential Services, Population-Specific

☐ ASAM Level 3.5: High-Intensity Residential Services, Non-Population Specific

☐ ASAM Level 3.2-WM: Clinically Managed Residential WM

SCREENED POSITIVE FOR INPATIENT TREATMENT

☐ ASAM Level 3.7-WM: Medically Monitored Inpatient WM

☐ ASAM Level 4-WM: Medically Managed Intensive Inpatient WM

REFERRED TO OTHER SUPPORT SERVICES

☐ Recovery Support Services

☐ Recovery Bridge Housing (requires concurrent enrollment in ASAM 1.0, 2.1, 1-OTP, or 1-WM)

☐ Other (Specify): _____

Client Referred to SUD Treatment: ☐ Yes ☐ No ☐ Refused

If Yes, complete the following information:

Name of Treatment Agency: _____

Address: _____ Phone: _____

Contact Person: _____ Email: _____

Appointment Date: _____ Time: _____

If client is referred to SUD treatment, please complete Release of Information (ROI) form
ROI – In Network Provider; ROI – Out of Network
The Release of Information (ROI) form has been signed. ☐ Yes ☐ No

Section 3: Treatment Provider Must Complete this Section and Return to CENS

Client showed up to appointment: ☐ Yes ☐ No	If no, rescheduled to: _____ Date _____ Time	

If admitted LOC is different than the ASAM Co-Triage LOC, specify below: _____ (Specify LOC)	If admitted:	Admission Date:	Expected Completion Date:
		Weekly Treatment Hours:	Admission Counselor's Name:

Please return this form to the CENS via [Secure] FAX or email upon Admission, No Show, or Rescheduled Appointment.

Comments: