SAN BERNARDINO COUNTY
Behavioral Health
621 East Carnegie Drive, Suite 210, San Bernardino | Phone: 800-968-2636 • Fax: 909-381-2172
www.SBCounty.gov

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 an Authorization for Release of Protected Health 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
☐ Youth Intensive Outpatient Treatment (IOT)
☐ Adult Outpatient Treatment
☐ Recovery Services at a Recovery Center
☐ Care Coordination

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:		
Appointment:	Date:	Time:

Comments: