**Substance Use Disorder Professional (SUDP) Referral**

[dcyfsudpreferrals@dcyf.wa.gov](mailto:dcyfsudpreferrals@dcyf.wa.gov) Date 0f Referral:

Client information

|  |  |  |
| --- | --- | --- |
| Name: | FAMLINK Person ID: | DOB: |
| Phone: | Email: | Address: |
| Caregiver information, if applicable: | | Insurance Coverage: |
| Case Name: | FAMLINK Case ID # | Drop down, CPS, FAR, legally free |
|  |  |  |

Additional information Service request:

DCYF Caseworker information

|  |  |  |
| --- | --- | --- |
| Caseworker: | Email: | Phone: |
| Supervisor: | Email: | Phone: |

Services needed: To be filled out by SUDP

Complete Drug and Alcohol assessment  Reason:

|  |  |  |
| --- | --- | --- |
| Collaboration | Provider Engagement | Case management |
| (SBIRT)  Screening, Brief Interventions & Treatment | Attend Case staffing | Meet with client |
| American Society of Addiction Medicine (ASAM) | Education on Prevention | Meet with client’s supports, ie identified family. |
| (MOUD)  Medications for Opioid use Disorder | Develop relapse prevention with client. | Meet with SUD agencies to connect client with services. |
| (UNCOPE)  Used, Neglected, Cut Down, Objected Preoccupied, Emotional Discomfort | Household, family member screen for SUD services, if needed. | Facilitate appropriate Release of information/Consents |
| Collaboration with caseworker on client progress and needed supports. | Connections to community providers | Appointment for Assessment & rescheduling when missed. |

Additional Assistance/Comments

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Social Worker Signature |  | Print Name |  | Date |

Please contact James Vallembois, SUD Program manager, [james.vallembois@DCYF.wa.gov](mailto:james.vallembois@DCYF.wa.gov) with any questions.