MCOSA
MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE

MCOSA: Care Coordinator Referral

Date of Referral:_____

Staff Completing Referral:_____ Phone: _____

Provider Agency:_____

CLIENT INFORMATION

Name: _____ FOCUS ID:_____ D.O.B.:_____

Phone Number: _____ Other Contact Number: _____

Alternate Contact Person:_____ Phone: _____

Was client provided notice that outreach would occurr? Yes ☐ No ☐

Primary Drug of Choice: _____ Secondary Drug of Choice: _____

Indication of Mental Health Issues: _____

Is the client pregnant? Yes ☐ No ☐ Is the client an IV drug user? Yes ☐ No ☐

MDOC involvement? Yes ☐ No ☐ Are they a parent with CPS involvement? Yes ☐ No ☐

Aftercare services established? Yes ☐ No ☐ N/A ☐ Where: _____

Current living situation (if address known please include):_____

_____

_____

Reason for referral: _____

_____

_____

SUD SERVICE STATUS:

Project ASSERT ☐ Unsuccesful discharge ☐ Successful discharge ☐

Unplanned absence ☐ Terminated from treatment ☐

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