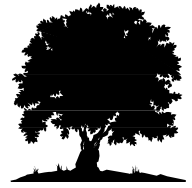


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**Before completing the Substance Use Disorders (SUD) Referral Form, please complete the inclusion and exclusion criteria listed below:**

**Inclusion Criteria (If left blank this form will be returned to you):**

The client is dually diagnosed (developmental disability and co-occurring D.S.M.-V S.U.D. issue) and be able to provide documentation of these diagnoses.

**Yes.** Client’s SUD diagnosis (check all that apply):

- |                                       |                                       |  |                                     |
|---------------------------------------|---------------------------------------|--|-------------------------------------|
| Alcohol:                              | <input type="checkbox"/> Use Disorder | <input type="checkbox"/> Intoxication  | <input type="checkbox"/> Withdrawal |
| Caffeine                              |                                       | <input type="checkbox"/> Intoxication) | <input type="checkbox"/> Withdrawal |
| Cannabis:                             | <input type="checkbox"/> Use Disorder | <input type="checkbox"/> Intoxication  | <input type="checkbox"/> Withdrawal |
| Phencyclidine:                        | <input type="checkbox"/> Use Disorder | <input type="checkbox"/> Intoxication  |                                     |
| Hallucinogen:                         | <input type="checkbox"/> Use Disorder | <input type="checkbox"/> Intoxication  |                                     |
| Inhalant:                             | <input type="checkbox"/> Use Disorder | <input type="checkbox"/> Intoxication  |                                     |
| Opioid:                               | <input type="checkbox"/> Use Disorder | <input type="checkbox"/> Intoxication  | <input type="checkbox"/> Withdrawal |
| Sedative, Hypnotic,<br>or Anxiolytic: | <input type="checkbox"/> Use Disorder | <input type="checkbox"/> Intoxication  | <input type="checkbox"/> Withdrawal |
| Stimulant:                            | <input type="checkbox"/> Use Disorder | <input type="checkbox"/> Intoxication  | <input type="checkbox"/> Withdrawal |
| Tobacco:                              | <input type="checkbox"/> Use Disorder |  | <input type="checkbox"/> Withdrawal |
| Other/Unknown:                        | <input type="checkbox"/> Use Disorder | <input type="checkbox"/> Intoxication  | <input type="checkbox"/> Withdrawal |

**No.** If you believe the client has an undiagnosed SUD diagnosis, please describe the client’s current symptoms (the reason you are making the referral):

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**Exclusion Criteria (check all that apply):**

The person has a history of being AWOL and this issue is part of the person’s current treatment plan/interventions.  Yes  No

The person has a high degree of self injurious behavior management as part of their current treatment plan/interventions.  Yes  No

The person has a high degree of (check all that apply):

physical aggression  verbal aggression  property destruction

The person has a seizure disorder not reliably controlled by medication.  Yes  No

The person requires assistance with bathroom use.  Yes  No

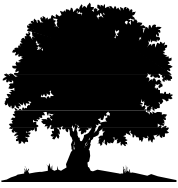
The person has a history of fire setting behavior.  Yes  No

The person has a history of inappropriate sexual behavior.  Yes  No

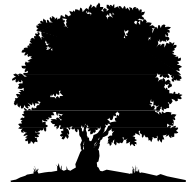
The person does not use words to communicate and does not have appropriate facilitation available.  Yes  No

***Locations:***

<p><i>Center for Personal Growth, Inc.</i>          4656 30<sup>th</sup> St.          San Diego, Ca. 92116</p>	<p><i>San Diego Center for Family Therapy, Inc.</i>          124 East 30<sup>th</sup> St., Suite A1          National City, Ca. 91950</p>	<p><i>Exodus Recovery, Inc.</i>          550 West Vista Way, Suite 109          Vista, Ca. 92083</p>
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If you answered “Yes” to any exclusion criteria, please provide details:

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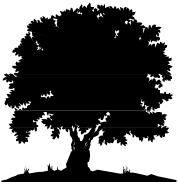
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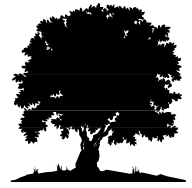
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**General Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone (Check one:  Home  Cell): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Type of residence: \_\_\_\_\_

Email: \_\_\_\_\_

**At which location would you like to receive services? Check all that apply:**

San Diego  National City  Vista

**Emergency Contact Information:**

Name: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Telephone (Check one:  Home  Cell): \_\_\_\_\_

**Designated SUD Support Person (Required/Mandatory):**

Part of the requirement for enrolling a client in the SUD program is that clients have a Designated Support Person. This person should be someone who knows the client well and has frequent and regular contact with the client. This person will be required to accompany the client to and participate in the SUD Support Person’s group once per month on a designated Wednesday night from 6:00 pm to 7:00 pm. Please ensure you have explained the responsibilities of this role to the designated support person and they have agreed to fulfill this role prior to submitting the referral form. **If left blank, the referral will not be processed and this referral form will be returned to the SDRC SC.** Who will be the client’s designated support person:

Name: \_\_\_\_\_ Tel.#: \_\_\_\_\_ Relationship: \_\_\_\_\_

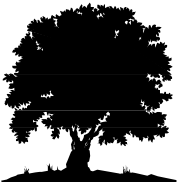
**Other People who provide support to the client:**

Name: \_\_\_\_\_ Tel.#: \_\_\_\_\_ Relationship: \_\_\_\_\_

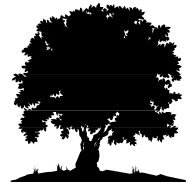
Name: \_\_\_\_\_ Tel.#: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**Legal Representative:**

Does the client have a conservator?

- Yes **If Yes...YOUR CONSERVATOR MUST ATTEND THE INTIAL SCREENING APPT.**  
 No

If Yes, please provide the following information:

Name of conservator or legal representatives: \_\_\_\_\_

Telephone number of conservator or legal representative: \_\_\_\_\_

**Note to SDRC Service Coordinator:**

Thank you for referring this client to the SUD Group. Please submit two POS' for these services (one for group therapy services and one for individual therapy services). The initial POS for group therapy services should be submitted for 64 units and have a time frame of one year. The initial POS for individual therapy services should be for 34 units and should also have a time frame of one year. Please use the date of the referral form as the start date for these POS'. Our vender number with the SDRC is: PY2294 (ages 18-20) and Service Code 115 or PY2295 (ages 21+) and Service Code 117. In addition, please forward the following collateral information:

- Consumer Information Sheet
- Individual Program Plan (IPP)
- Individual Program Plan (IPP) Services and Supports Form
- Client Developmental Evaluation Report (CDER)
- Psychological Report/Evaluation
- Behavior Assessment
- Social Summary/Assessment
- Medical Evaluation

*By signing below, I certify that I have submitted the requested POS' for approval and requested collateral information be sent to the Center For Personal Growth.*

SDRC SC Print Name: \_\_\_\_\_

SDRC SC Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Tel.#: \_\_\_\_\_

- 4355 Ruffin Road, San Diego, Ca. 92123
- 8760 Cuyamaca St, #100, Santee, Ca. 92071
- 2727 Hoover Ave, #100, National City, Ca. 92150
- 5931 Priestly Drive, Suite 100, Carlsbad, CA 92008

Thank you for completing the Substance Use Disorders Referral Form. Please scan and email this form to [BNewcomer@centerforpg.com](mailto:BNewcomer@centerforpg.com).

This information will be reviewed by a staff member who will contact you to discuss the content and/or schedule an initial screening appointment with the client.

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