Landmark OTP Referral Form

Central New York Services, Inc.
Phone: 315-624-9835
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Fax: 315-624-9838

INDIVIDUAL INFORMATION			
DATE:	**NAME:**	**DOB:**	**Male Female**
ADDRESS: **OK to send mail? Yes No**		**Phone:** **_____(H)_____(C)** **OK to leave message? Yes No** **OK to identify program/agency? Yes No**	
Ethnicity: Caucasian African American Hispanic Asian Other (Specify)			
Primary Language:		**Marital Status:**	
Are you a Veteran? Yes No **Branch of Military?**		**Legal Status:** **Parole Probation Pending None**	
Emergency Contact:		**Relationship:**	**Phone:**
Referral Source:		**Referral Phone:**	
Person Completing the Form:			

INSURANCE INFORMATION	
Insurance Company:	Insurance ID:
If Medicaid, Managed Care Plan:	
Employment Status:	

RECENT SUBSTANCE USE		
Which substances have been used in the past 3 months? (check all that apply)		
☐ Alcohol	☐ Crack	☐ Psychoactive Drugs
☐ Amphetamines	☐ Ecstasy	☐ OTC Codeine
☐ Barbiturates	☐ Inhalants	☐ RX Opioids
☐ Benzodiazepines	☐ Hallucinogens	☐ Steroids
☐ Cannabis	☐ Heroin/Opium	☐ Tobacco
☐ Caffeine/Energy Drinks	☐ Methamphetamines	☐ Other:_____
☐ Cocaine	☐ Methadone	☐ Unknown

OPIOID SUBSTITUTION THERAPIES
Current prescribed treatment: Methadone/Suboxone/Vivitrol/Other:_____ Current Dose:_____ Current Prescriber/Treatment Provider: Duration of treatment:

REASON FOR REFERRAL
Briefly note the reason for the referral and any additional comments