Mailing: P.O. Box 29819 Honolulu, HI 96820
Physical: 1130 N. Nimitz Hwy, Unit A226
Honolulu, HI 96817
PH: (808) 847-4227
FAX: (808) 842-0044

Kokua Support Services
A Path for a Better Tomorrow

SUBSTANCE ABUSE TREATMENT
REFERRAL FORM

KSS Use Only
Appt Date: **Appt Time:**

SERVICES NEEDED:

- ☐ **Drug & Alcohol Assessment**
- ☐ **Intensive Outpatient Treatment**
- ☐ **Outpatient Treatment**
- ☐ **Substance Abuse Education**
- ☐ **Anger Management**

REFERRAL SOURCE INFORMATION:

Name: _____
Title/Relation: _____ Organization (If applicable): _____
Phone: _____ Fax: _____
Email: _____
Comments: _____
_____

PERSONAL

CLIENT INFORMATION:

Last name: _____ First: _____ Middle/Maiden: _____
Address: _____
City: _____ Island: _____ Zip Code: _____
Gender: M / F
Marital Status - Circle One: Single Married Separated Divorced Widowed
Are you employed? Yes / No Circle One: Full Time / Part Time
If **Yes**, Name of Employer: _____
Health Insurance: _____
Policy Number: _____

Birth Date:

Social Security #:

Clients Contact #:

Primary Language Spoken:

LEGAL & DRUG

Are you currently charged with a crime? Yes / No If **Yes**, List the charge(s): _____
Are you sentenced? Yes / No
Probation/Parole Officer's Name: _____ Phone Number: _____
Have you ever been convicted of an offense that was sexual in nature? Yes / No
Have you ever been convicted of a violent crime? Yes / No

ALCOHOL/DRUG USE:

Drug Used	Date of Last Use	How Much	How Often

PREVIOUS SUBSTANCE ABUSE TREATMENT:

Where	Date(S) You Attended	Level Of Care Completed	Reason For Discharge

COLLATERAL/MEDICAL/PSYCHIATRIC

Do you have **ANY** history of violence? Yes / No
If Yes, Please explain: _____
Do you have a case manager? Yes / No
If Yes, case manager's Name: _____ Phone Number: _____

MEDICAL:

Medical Condition(s)	How Long	Treating Physician	Medication(s)

PSYCHIATRIC:

Psychiatric Condition(s)	How Long	Treating Physician	Medication(s)

All of the above information is required to process referrals for entrance into substance abuse treatment services