# *Appendix B*
# *CLIENT REPORT FORM*

***ABH Contact:*** ***Referral Date/Time:*** ***Ref #:***

**ADVANCED BEHAVIORAL HEALTH, INC.**
Middlesex Corporate Center, 8th Floor, Middletown, CT 06457
Phone: 860.638.5309 Fax: 860.638.5302

## *PROJECT SAFE*

DCF Substance Abuse Services for Primary Care Givers

To:_____ and _____
**DCF SOCIAL WORKER** **ABH INTAKE WORKER**

DATE:_____

CLIENT NAME:_____ ABH CLIENT ID #_____

**The above client received: (Check all that apply)**

☐ Evaluation ☐ Drug Screen ☐ Hair Test

**TREATMENT RECOMMENDED: CHECK ONE**
**START DATE FOR BELOW TX:_____**

☐ No Treatment Recommended

☐ Individual Therapy

☐ Group Therapy

☐ Early Intervention

☐ Family/Couple Therapy

☐ Intensive Outpatient (IOP)

☐ PHP

☐ METHADONE (Not funded by DCF contract)

☐ INPATIENT DETOX (Not funded by DCF contract)

☐ AMBULATORY DETOX (Not funded by DCF contract)

☐ RESIDENTIAL SERVICES (Check below; not funded by DCF Contract)

With Children_____ Without Children_____

**Clinician Name: _____ Date:_____**
**(Please Print/Required field)**

***SIGNATURE*_____**

***Name of Provider*** _____