LaMoor Family 1st Services

Phone: 405 424-MOOR *6667 ~ Fax: 405 400-0225

SAP/DOT

NEW CLIENT REFERRAL INFORMATION FORM

Referral Date _____ Completed by: _____

Last Name: _____ First Name _____

Home Address: _____ City: _____ ST_____ Zip Code: _____

Phone Number: _____ DL#: _____ SS# _____

DOB: _____ Age: _____ Ethnicity: _____ Gender: _____

Employer: _____ Phone: _____ Fax: _____

Address: _____ City: _____ ST _____

Zip Code: _____ Supervisor Name: _____ Phone: _____

DER Coordinator: _____ **Phone:** _____

Fax: _____ **Email**: _____

DOT OPERATING ADMINISTRATION: _____

Please Identify As Applicable: (Name/Phone #)

DER: _____

MRO: _____

EAP: _____

Reason for Referral or Services:

☐ Random ☐ Pre-Employment ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Follow-Up ☐ Return to Duty

Other: _____

Date of Test or Refusal: _____ Substance(s) on UA: _____

Any previous drug/alcohol related work violations? ☐Yes ☐ No If yes, give brief description of incident including date of incident and sanctions. _____

_____

_____

Any previous failed drug test? ☐ Yes ☐ No If yes, give brief description of incident including date of incident and sanctions. _____

For Office Use Only **Date received:** _____

Assigned SAP: D. Lowe LADC, SAPQ _____ Date: _____