



COLUMBIA COUNTY

608-742-9227
FAX: 608-742-9700

E-MAIL: DHHS@co.columbia.wi.us
WEBSITE: www.co.columbia.wi.us

Health and Human Services
111 E. Mullett Street

Mailing Address: P.O. Box 136
Portage, WI 53901-0136

Medication Assisted Treatment (MAT) Program

Date of Referral:	Date Received by BHLTS:
Legal Name:	Gender:
Date of Birth:	Preferred name and/or pronouns:
Race / Ethnicity:	
Social Security Number:	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Referral Source and contact information:	

Consumer's Mailing Address:	
<input type="checkbox"/> Check box if currently incarcerated.	Bond Conditions:
Release Date:	Public Defender:
	Probation Agent:
Phone Number:	Another Phone:
Consumer Email Address:	
Best way to contact: <input type="checkbox"/> Call <input type="checkbox"/> Text <input type="checkbox"/> Email	

Known Mental Health Diagnoses:	
Currently working with a therapist?: <input type="checkbox"/> No <input type="checkbox"/> Yes, name and agency:	
Medical Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes MA#	List Insurance:

People involved with the person listed on the referral:

(family, friends, psychiatrist, neighbor, peer support, mentor, teacher, probation & parole, etc.)

<u>Name</u>	<u>Relationship</u>	<u>Address (if different from applicant)</u>	<u>Phone Number</u>

Columbia County Health and Human Services has permission to call/text/e-mail/fax people listed on the referral for coordination of this referral: _____.

(consumer signature)

Substance Use Information

(Heroin Abuse, Prescription Medication, Opioids, Stimulants, Alcohol, Other)

Primary Substance	Substance Problem:		Usual Route of Administration:	
	Frequency in the past 30 days:		Age of First Use:	
	Date of last use:			
Secondary Substance	Substance Problem:		Usual Route of Administration:	
	Frequency in the past 30 days:		Age of First Use:	
	Date of last use:			
Tertiary Substance	Substance Problem:		Usual Route of Administration:	
	Frequency in the past 30 days:		Age of First Use:	
	Date of last use:			

Current Cravings:

None-----Very Much So
0---1---2---3---4---5---6---7---8---9---10

Prior Overdose: Yes No Unknown
If yes, Narcan used: Yes No Unknown
Number of overdoses:

Education:		Employment Status:	
Living Arrangements:		Number of Arrests in the past 30 days:	
Number of Support Groups Attended in the past 30 days:			

Return the completed referral to the MAT Coordinator by mail, email, or fax.

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