MICHIGAN DEPARTMENT OF CORRECTIONS
SUBSTANCE ABUSE TREATMENT REFERRAL

CFJ-306
03/2020

Date	Offender Number	Offender Name	Offender DOB

Offender Address	Offender Phone Number

Supervising Agent	Email	Telephone

Supervisor	Email	Telephone

Primary:
Drug of Choice: ☐ Alcohol ☐ Cocaine ☐ Opiates ☐ Meth ☐ Other
If other explain _____

Route of Administration: ☐ Injection ☐ Oral ☐ Nasal ☐ Smoke

Date of Last Use: _____ Frequency of Use ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Secondary:
Drug of Choice: ☐ Alcohol ☐ Cocaine ☐ Opiates ☐ Meth ☐ Other
If other explain _____

Route of Administration: ☐ Injection ☐ Oral ☐ Nasal ☐ Smoke

Date of Last Use: _____ Frequency of Use ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

The offender is unable to control their substance use as evidence by: (check all that apply)

- ☐ Offender has expressed desire for treatment
- ☐ Two or more positive drug or alcohol tests within last six months
- ☐ Family member has contacted agent to express concern regarding offender's substance abuse
- ☐ Unsuccessful termination from a substance abuse treatment program within the last six months
  Date: _____
- ☐ Recent arrest by criminal justice agency for use/possession of alcohol or controlled substance
- ☐ Other
  If other explain _____

Previous treatment: ☐ Outpatient Number of times: _____ Dates (M/Y) _____
☐ Residential Number of times: _____ Dates (M/Y) _____

Offender has history/conviction for: ☐ Arson ☐ Sex Offense ☐ OUIL 3rd

Current medical condition: ☐ Cardiac ☐ Back ☐ Diabetes ☐ High BP ☐ Pregnancy ☐ Seizure ☐ Other
If other explain _____

Current or previous psychiatric problems: ☐ Yes ☐ No
If yes explain _____

On Medications: ☐ Yes ☐ No
If yes list _____

30 Day Supply of Meds available: ☐ Yes ☐ No

Availability: Immediately Available ☐ or Date Available: _____