5284 Paylor Lane Sarasota, FL 34240 Phone: 941-361-1504 Fax: 941-444-5785 Email: CAPTA@sccfl.org

# CAPTA REFERRAL FOR SERVICES

**EMAIL: CAPTA@sccfl.org**

**Screening Eligibility**

1. Is substance/alcohol misuse impacting the family? Yes☐ No☐
2. Is the Mother currently pregnant? Yes☐ No☐
   If so, when is her due date? ________________________
3. Did the Mother screen positive for substances during her pregnancy? Yes☐ No☐
4. Did the Mother admit to prior substance misuse during an interview? Yes☐ No☐
5. Did the Mother test positive for substances at the time of delivery? Yes☐ No☐
   If so, date of last drug screen and positive for: ____________________________
6. Did the Infant test positive for substances at the time of delivery? Yes☐ No☐
7. Has the Infant experienced any withdrawal symptoms? Yes☐ No☐
8. Is the Infant under 12 months of age? Yes☐ No☐

**Date of Request: ______________**

**Referring Agency (select one):**

☐ MSO ☐ DCF ☐ ERAT SMS/FSS ☐ In Home Non-Judicial ☐Other: ________________

**Referring Person: ______________________________**

**Email:** **Cell:**

**Supervisor of Referring Person: ________________________________**

**Email:** **Cell:**

**Case Name: __________________________________** **Case Number: ______________________**

**Please list all household members including children in the home:**

| Name | Relationship | DOB | Address | Phone # | FSFN ID |
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**Reason for referral (please include any of the following: results of last drug screening/prior treatment provider/prenatal care/prenatal exposure/medical and/or developmental concerns/services involved with the family):**