ACBC
Addiction Center of Broome County

Peer Services Referral Form

Updated: March 2025

Demographic Information

Name: _____

Date of Birth: _____

Address: _____

_____

County: _____

SSN: _____

Phone: _____

Broome County Sheriff's Office

Arrival Date: _____

Release Date: _____

Lawyer/Attorney: _____

Engaged with MOUD/MAT: _____

Referral Source Details

Date: _____

Referring Provider: _____

Agency: _____

Agency Phone Number: _____ Ext._____

Are you referring yourself for peer services? ☐ Yes ☐ No

Participant Needs

What needs does the participant have?

- ☐ SUD Services
- ☐ Recovery Support Services
- ☐ Crisis Services
- ☐ Detox
- ☐ Inpatient Treatment
- ☐ Recovery Center
- ☐ MAT for OUD
- ☐ MAT AUD
- ☐ MAT for Other SUD
- ☐ Harm Reduction Services
- ☐ Primary Care
- ☐ HIV/HCV/ STD Testing
- ☐ Crisis Services
- ☐ Employment Voc/Ed
- ☐ Food Resources
- ☐ NYS ID
- ☐ Sheriff's ID
- ☐ Housing/ Shelter Resources
- ☐ Transportation
- ☐ Family Support Services
- ☐ LGBTQIA + Services
- ☐ Wound Care
- ☐ Mental Health Resources
- ☐ Therapy/Counseling Services
- ☐ Travel Training*
- ☐ Clothing
- ☐ Mental Health Medications
- ☐ Syringe Services
- ☐ Hygiene
- ☐ Assistance at DSS
- ☐ All Weather Supplies
- ☐ HH Care Management
- ☐ Cell Phone
- ☐ HIV/HCV Testing
- ☐ Other: _____

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Insurance

Does this person have health insurance? ☐ Yes or ☐ No *If yes what is the CIN?* _____
*** CIN includes the following format: 2 letters, 5 numbers, 1 letter, all with no spaces*

Substance Use & History

Does the individual have a history/current of any of the following?

- ☐ History of criminal arrest
- ☐ Legal involvement
- ☐ Homeless/unhoused
- ☐ LGBTQIA+
- ☐ Have a mental health condition
- ☐ Pregnant/ Postpartum
- ☐ Veteran
- ☐ Has a physical disability
- ☐ Refugee
- ☐ Immigrant
- ☐ Other Priority Population
- ☐ Prefers not to answer

Does this person use substances intravenously? ☐ Yes ☐ No

Has the participant used any of the following in the past 30 days?

- ☐ Opioids
- ☐ Alcohol
- ☐ Benzodiazepine
- ☐ Cocaine
- ☐ Crack Cocaine
- ☐ Methamphetamine
- ☐ Other: _____
- ☐ Xylazine
- ☐ None of the above

Current Use of Substances? ☐ Yes ☐ No

If yes, what substances is the participant actively using? _____

Have you/ the individual been offered/connected to harm reduction services? ☐ Yes ☐ No

Does this person have Naloxone? ☐ Yes ☐ No

Has the participant overdosed in the past? ☐ Yes ☐ No *If Yes, how many in the last 12 months?* _____

Has the individual sought out treatment, recovery, or harm reduction services in the past 6 months? ☐ Yes ☐ No

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Race	Hispanic Origin	Gender Identity
☐ White/Caucasian	☐ Cuban	☐ Woman
☐ Alaska Native	☐ Mexican	☐ non-binary
☐ American Indian	☐ Puerto Rican	☐ Intersex
☐ Asian	☐ Other Hispanic	☐ Uses a Different Term
☐ Black/African American	☐ Hispanic, Not Specified	☐ Man
☐ Hawaiian/Pacific Islander	☐ Not of Hispanic Origin	☐ Two Spirit
☐ Prefers not to Answer	☐ Prefers not to Answer	☐ Questioning/ Unsure
		☐ Prefers not to Answer
		☐ Transgender
		☐ Gay/ Lesbian

Current Providers

Medical: _____

Mental Health: _____

Substance Use: _____

Peer Support Services: _____

Please return by secure email to referral@acbcservices.org or via fax to the preferred location:

Binghamton 607-724-4626 Endicott 607-239-4115 Norwich 607-373-3864

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ACBC Management Use Only

Date of Referral Submitted: _____

Role of Staff Completing Referral

- ☐ CRPA/CRPA-P
- ☐ Non-Certified Peer
- ☐ Nurse Practitioner
- ☐ Physician's Assistant
- ☐ Harm Reduction Specialist
- ☐ CASAC/ CASAC-T
- ☐ LMHC/ LMSW/ LCSW
- ☐ Registered Nurse (RN)
- ☐ Law Enforcement
- ☐ Family/ Friend
- ☐ I am referring myself
- ☐ Medical Assistant
- ☐ BCSO Employee

Peer Referral Allocation

Date of Referral Allocation: _____

- ☐ PES
- ☐ AFN
- ☐ OES
- ☐ SEP
- ☐ BCSO Peer
- ☐ Non-Medical Transportation
- ☐ SOR 4 (CRPA-Youth)
- ☐ OD2A- HR Local
- ☐ OD2A- Rural
- ☐ BCHD Harm Reduction Stigma Specialist
- ☐ ESG
- ☐ Code Blue
- ☐ Family Navigation
- ☐ Health Home Enrollment

Quality Indicators

Was the participant connected to a peer within 24 hours? ☐ Yes ☐ No

Did the peer assigned to the participant connect within the same business day? ☐ Yes ☐ No

If not, why? _____

Assignment/ Cost Center

Assigned Peer Advocate: _____

Provider Number: _____

Cost Center: _____

Manager Signature: _____