**xx JOB CORPS CENTER**

**TEAP/TUPP REFERRAL FORM**

Check all that apply: [ ]  TEAP/TUPP Referral [ ]  Suspicion Testing [ ]  Breathalyzer

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Student Name:** |  | **DOB:** |  | **Date of Referral:** |  |
| **Student ID#:** |  | **Referred by:**  |  |

**TEAP/TUPP REFERRAL BECAUSE:**

|  |  |  |
| --- | --- | --- |
| [ ]  Student wants to self-refer to TEAP/TUPP | [ ]  Talk of relapsing | [ ]  Seen in high-risk places (bar/liquor store) |
| [ ]  Other students expressed concerns | [ ]  Interacting with known users | [ ]  To cease using nicotine/tobacco/vaping |

**REFERRAL FOR SUSPICION TESTING BECAUSE OF MULTIPLE AND NOTABLE SIGNS OF USE:**

**Recent use of Alcohol/Drugs as Evidenced by (Check all that apply):**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Aggressive behavior | [ ]  Slurred speech | [ ]  Poor coordination | [ ]  Staggering |
| [ ]  Drowsiness/nodding off repeatedly  | [ ]  Non-responsive sleepiness | [ ]  Odors of Substances | [ ]  Bloody nose |
| [ ]  Changes in personality | [ ]  Loss of motivation | [ ]  Nausea/vomiting | [ ]  Increased irritability |
| [ ]  Dry mouth/dehydration | [ ]  Poor judgment  | [ ]  Possess paraphernalia | [ ]  Dilated or pinpoint pupils |
| [ ]  Change in behaviors/increase impulsivity | [ ]  Rapid mood changes | [ ]  Bloodshot eyes | [ ]  Excessive scratching |
| [ ]  Confusion/disorganized thinking | [ ]  Changes in breathing | [ ]  Flushed face/skin | [ ]  Paranoia |
| [ ]  Body sores | [ ]  Other:  |

**Incident Report Written?** [ ]  Yes [ ]  No **Incident Report Sent to TEAP?** [ ]  Yes [ ]  No

**REFERRAL BASED ON ALCOHOL TEST RESULTS (Attached printout from breathalyzer if possible)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Test 1 Result | TIME | Test 2 Result | TIME | Test 3 Result | TIME |
|  |  |  |  |  |  |
| Test 4 Result | TIME | Test 5 Result | TIME | Test 6 Result | TIME |
|  |  |  |  |  |  |

NAME OF STAFF PERFORMING TEST: /

 (Print Name) (Signature)

**TEAP USE ONLY**

|  |  |
| --- | --- |
| Relevant Clinical Factors: |  |
| Recommendation for Suspicion Testing: |  |
| **Signature**:  **Date:** |

**CENTER DIRECTOR/DESIGNEE USE ONLY**

[ ]  **Drug Test OR** [ ]  **TEAP Program**

[ ]  **Explain Decision:**

**Center Director's Signature:** **Date:**

Final Disposition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TEAP Specialist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEND TO HEALTH AND WELLNESS CENTER FOR INCLUSION IN SHR**