**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**