Referral Form for Men's Residential Treatment

Name: _____ Date of Birth: _____

Physical Address: _____

Mailing Address: _____

Primary Phone Number: (_____)_____-_____

Secondary Phone Number: (_____)_____-_____

How were you referred to the Highland Recovery Center?

_____

_____

Marital Status: ○ Single ○Married ○ Divorced ○ Partnered

Employment Status: _____

Substance Use History (please check all that apply):

○ Alcohol ○ Marijuana ○ Methamphetamine ○ Heroin ○ Cocaine/Crack ○ Hallucinogenics
○ Benzodiazepines ○ Opiates ○ Other _____ ○ IV Drug Use

Please indicate last date of use and amount used for above identified substances**:**

_____

_____

Significant Medical History:

○ Seizure Disorder ○ Hepatitis C ○ Tuberculosis ○ Diabetes ○ Traumatic Brain Injury
○ Other that may require 24/7 medical care.

*Note: These issues do not mean you will be disqualified from entrance into the program.

Please note any other significant medical conditions:

_____

_____

_____

Nicotine use: ○ Non-user ○Periodic user ○ Daily user

Current Medication:

_____

_____

_____

History of Treatment for Mental Health/Substance Use and any know Diagnosis:

○ Inpatient Detoxification ○ Inpatient Mental Health ○ Outpatient Substance Use
○ Outpatient Mental Health ○ Residential Substance Use

Please explain above identified treatment (Where and When)**:**

_____
_____
_____

Current/Pending/Past legal History (If Applicable):

_____
_____
_____
_____

Have you participated in a Treatment Court program? ○ Yes ○ No
If yes, please explain the outcome:

_____
_____

Insurance (If uninsured please note): _____

Primary Care Physician Contact Information:

Name: _____ Phone Number: (_____)_____-_____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

Phone Number: (_____)_____-_____

Probation/Parole Officer Contact information (If Applicable):

Name: _____ County:_____

Phone Number: (____)_____-_____ Fax Number: (____)_____-_____

Attorney Contact Information (If Applicable):

Name:_____ Law Firm:_____

Phone Number: (____)_____-_____ Fax Number: (____)_____-_____

By signing below you attest that the information you have provided in this referral form is accurate to the best of your knowledge. Your signature below and on the attached Releases of Information (ROI), acknowledges that the Highland Recovery Center (HRC) may contact you, your referral source, and any relevant legal/treatment entities involved in your admission process, for the purpose of obtaining more information pertaining to your current status and eligibility for admission, as further delineated by the accompanying ROI. Furthermore, this will serve to relay any relevant information regarding the nature of the program, and/or your date of admission should you be placed on the program's waiting list.

Printed Full Name: _____

Signature: _____ Date:_____

Attached to this referral form you will find two blank Releases of Information (ROI) for Highland Rivers Health CSB to communicate with any relevant parties involved in your possible admission and treatment. Releases of Information may be rescinded at any time by the applicant.

Please return this completed referral form to The Highland Recovery Center via mail, email or fax to the contacts listed below:

Address: The Highland Recovery Center
Attn: Justin Carson
323 Roland Road
Jasper, GA 30143
Fax: 706-253-1113

Email: justincarson@highlandrivers.org

For further Information please contact:

Justin Carson, MS, LPC, NCC
Residential Program Manager
Highland Rivers Health
The Highland Recovery Center
Phone: 706-253-1169 Ext: 5314

RELEASE OF INFORMATION

Highland Rivers Community Service Board

FILL OUT EACH SECTION WHERE INDICATED	**Consumer's Name:**

Section A – Authorization: [READ]

By signing this form, I authorize Highland Rivers, including any affiliated program, to use and disclose my individually-identifiable health information as specified below:

Section B – Authorized Recipients: [FILL-IN]

My information may be disclosed to / from: _____

Address:

Section C: Designation of records to be released [CHECK ALL THAT APPLY]

☐ Psychiatric/Psychological Records (evaluation, assessment, treatment, attendance and discharge plan)	☐ Clinic & Doctor Notes	☐ Group Notes
☐ Alcohol and/or Drug Abuse Treatment Records (assessment, treatment, attendance and discharge plan)	☐ Progress Notes	☐ Drug Screens
☐ Individual Service Recovery Plan	☐ Rehabilitation Plan	☐ Test/Lab Results
☐ Other: [specify] _____ ☐ **HIV/AIDS**	☐ Individual Education Support Plan/Family	☐ Prescribed Medications

Section D: Purpose of Disclosure [MUST CHECK AT LEAST ONE]

☐ Continuity of care	☐ Determination of benefits	☐ Compliance with services and treatment plan
☐ Coordination of services	☐ Determination of eligibility	☐ Compliance with court ordered treatment plan
☐ Adherence to subpoena(s)	☐ Representation of Consumer	☐ Treatment outcome and effectiveness
☐ If information is **not** drug and alcohol related and consumer declines to state purpose check here.		☐ Other:

If request is for a specific time period or program please specify:

Date From: To: Program:

Section E: Expiration [CHECK ONE AND SIGN]

I understand that this authorization will remain in effect for:

☐ One year **OR** ☐ Expiration date or event: _____

Signature of Consumer or Authorized Representative

Section F: Other Information

I understand that: (1) the Highland Rivers CSB cannot guarantee that the recipient of this information will not redisclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug rehabilitation patient records (42 CFR, Part 2); (2) except where I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from the Highland Rivers CSB; and (3) I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Highland Rivers CSB in reliance on this authorization before written notice of revocation is received (See Notice of Privacy Practices).

Signature of Consumer _____ Date _____ Time _____ AM/PM

Consumer's Date of Birth: _____ Last 4 digits of Consumer's Social Security Number: _____

_____ _____ _____ AM/PM

Signature of Parent or Legal Representative (if applicable) Date Time

_____ _____ _____ AM/PM

Signature of Witness (Title/Relationship to Consumer) Date Time

USE THIS SPACE ONLY IF CONSUMER WITHDRAWS CONSENT

Date revoked by Consumer: _____ Signature of Consumer _____