

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: _____
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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]

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

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Continuity of care | <input type="checkbox"/> Determination of benefits | <input type="checkbox"/> Compliance with services and treatment plan |
| <input type="checkbox"/> Coordination of services | <input type="checkbox"/> Determination of eligibility | <input type="checkbox"/> Compliance with court ordered treatment plan |
| <input type="checkbox"/> Adherence to subpoena(s) | <input type="checkbox"/> Representation of Consumer | <input type="checkbox"/> Treatment outcome and effectiveness |
| <input type="checkbox"/> If information is not drug and alcohol related and consumer declines to state purpose check here. | <input type="checkbox"/> 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 disclose 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: _____		
Signature of Parent or Legal Representative (if applicable) _____	Date _____	Time _____	AM/PM
Signature of Witness (Title/Relationship to Consumer) _____	Date _____	Time _____	AM/PM

USE THIS SPACE ONLY IF CONSUMER WITHDRAWS CONSENT

Date revoked by Consumer: _____ Signature of Consumer _____