

## Referral Form for Men's Residential Treatment



Please complete this form accurately and in its entirety. Completion of this form does not guarantee placement on the residential waiting list as a face to face screening is required for determination of eligibility (HRHCSB Policy # 636).

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Primary Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Secondary Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How were you referred to the Highland Recovery Center?

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**Marital Status:**  Single  Married  Divorced  Partnered

**Employment Status:**

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**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:

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**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:

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

**Current Medication:**

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**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):

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

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**Have you participated in a Treatment Court program?**  Yes  No

If yes, please explain the outcome:

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**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](mailto: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

<b>FILL OUT EACH SECTION WHERE INDICATED</b>	<b>Individual's Name:</b> _____	
<b>Section A – Authorization: [READ]</b>		
By signing this form, I authorize Highland Rivers, including any affiliated program, to use and disclose my individually-identifiable health information as specified below:		
<b>Section B – Authorized Recipients: [FILL-IN]</b>		
My information may be disclosed to / from: _____		
Address: _____		
<b>Section C: Designation of records to be released [CHECK ALL THAT APPLY]</b>		
<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"/> Substance Use Disorder 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
<b>Section D: Purpose of Disclosure [MUST CHECK AT LEAST ONE]</b>		
<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 Individual	<input type="checkbox"/> Treatment outcome and effectiveness
<input type="checkbox"/> If information is <b>not</b> substance use related and individual declines to state purpose check here.	<input type="checkbox"/> Other:	
<i>If request is for a specific time period or program please specify:</i>		
Date From: _____	To: _____	Program: _____
<b>Section E: Expiration</b>		
<i>I understand that this authorization will expire within one year of the date of my signature below unless I specify another date/event here:</i> _____		
<b>Section F: Other Information</b>		
I understand that: (1) the Highland Rivers CSB cannot guarantee that the recipient of this information will not re-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 an individual in a substance use 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 individual or as otherwise permitted by federal law governing confidentiality of substance use 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).		
<b>Signature of Individual</b> _____	Date _____	Time _____ AM/PM
Individual's Date of Birth: _____	Last 4 digits of Individual's Social Security Number: _____	
* _____ AM/PM		
<b>Signature of Parent or Legal Representative (if applicable)</b> _____	Date _____	Time _____
<b>*Must Specify Relationship to Individual (Parent, Guardian, etc.)</b>		

**USE THIS SPACE ONLY IF INDIVIDUAL WITHDRAWS CONSENT**

Date revoked by Individual: \_\_\_\_\_ Signature of Individual \_\_\_\_\_