MULTI-SERVICE REFERRAL FORM

Please note that any referral that is received by Sound Community Services that is not accompanied by a signed release of information as well as a signed referral form will not be accepted.

GUIDELINES FOR USE:

1. Complete all information (Social Security number must be noted on form).
2. Complete using information from current or most recent treatment provider.
3. Describe services currently received, service needs/current status and reason for referral.
4. List applicable insurance policy numbers.
5. List monthly amount received from applicable financial sources.
6. Attach a current list of medications, known allergies, and treatment provider.
7. Next of kin or emergency contact information, including individuals considered by person served to be natural supports. If person is conserved, attach a copy of the conservatorship decree.
8. Provide employment information including current status and goals.
9. Histories of inpatient hospitalizations, including reason, approximate dates, and lengths of stay.
10. Describe known risks, stressors, precipitators to hospitalization, and interventions successful in the past.
11. Indicate any requested service(s)/program(s) from SCSI with a check mark.
12. Indicate agency/provider to receive referral. Indicate any requested service(s)/program(s)
13. Referral not valid unless accompanied by signed Release of Information.
14. Please attach W-10, discharge summary, and/or most recent assessment, if applicable.
15. Indicate preferred initial contact for referral/assessment.

Provide printed name and signature of person filling out referral form, agency name and phone number in the space provided. Please fax to 860-333-6026, thank you.

Sound Community Services

SCSI OFFICE ONLY Received by: _______________

Date: _______________

A. DEMOGRAPHICS

Date of Referral: _______________

Name:_______________________________DOB:___________Age:__________SS#: __________________________

Physical Address:________________________________City:_____________________State:___________Zip:_________

(if different than physical address)

Mailing Address:________________________________City:_____________________State:___________Zip:_________

Phone: Primary Phone #__________________________Education Level:____________Veteran: □Yes □No

Race: (Check One) □Amer. Indian □Asian □Black □Pacific-Islander □White □Other________________

Gender: □Male □ Female   Primary Language: ____________________

B. DIAGNOSIS (DSM 5 Code)

PRIORITY	DIAGNOSIS

PSYCHOSOCIAL & CONTEXTUAL FACTORS

(GAF) __________

Stage of Treatment: [ ] Pre-engagement [ ] Engagement [ ] Early Persuasion [ ] Late Persuasion [ ] Early Active

[ ] Late Active [ ] Relapse Prevention [ ] In Remission / Recovery [ ] Not Applicable

****

C. CURRENT SITUATION / REASON FOR REFERRAL (Include current services received; natural and community supports; risk management and/or safety concerns; presenting needs, strengths, abilities, goals; areas requiring skill-teaching)

____

____

____

____

____

____

D. MEDICAL COVERAGE

Medicaid (Title XIX#):_______________Medicare #:__________________Other / #: _______________________________

Private Insurance Carrier & Policy #:____Group #:_____________

E. MONTHLY INCOME

Employment $:_____________SSD $:____________SSI $:_____________State Supplement $: _____________

Other $/and source: ____

F. MEDICATIONS & DOSAGES Known Allergies: ____

If referral is requesting medication services, please attach the last 6 months of records if applicable

Prescribing Physician / APRN:____________________________Agency:________________Phone: __________________

G. EMERGENCY CONTACT PERSON

Name:____Relation to Person Served: ____________________________

Address:____Phone: _________________________

Other Natural Supports: ____

H. HISTORY OF PSYCHIATRIC / SUBSTANCE ABUSE HOSPITALIZATIONS OR TREATMENT PROGRAMS

(Include PHP, IOP, Detox, Residential, Inpatient and/or Outpatient Treatment)

Facility	Dates

I. HISTORY OF RISK FACTORS (Check all that apply)

_____History of alcohol / drug use

_____History of arson

_____Sexually assaultive behavior

_____Assaults or threats of assault in hospital or community

_____Access to weapons

_____Returning to dangerous environment

_____Suicidal behavior/threats/gestures/attempts

_____Non-compliant with orders re: serious medical condition

SoundCommunityServices

Comment on checked items:

____
____
____
____
____

Known stressors / Indicators to decompensation / Recommended Interventions:

____
____
____
____
____

J. IF REQUESTING SERVICES FROM SOUND COMMUNITY SERVICES (Check all that apply):

_____Medication Management _____Individual Therapy _____Outpatient Group

_____Intensive Outpatient Program (New London)

_____Intensive Outpatient Program (Norwich)

_____Bent Crandall Dual-Diagnosis Program______Supervised Apartment Program

_____Community Support Program (Case Management) _____Employment Services

_____Social Rehabilitation/Oasis ______AXS Center (Young Adults)

M. CONTACT INFORMATION

Name of Contact Person for Referral:_____________________________Signature:________________________

Referring Agency Name:______________________________________Phone/Fax #: _____________________

Referring Contact Signature:____

Signature of Person Served: ____

Preferred Contact to Initiate Services:____

☐Please contact referral source

☐Please contact Person Served/Client

Referral not valid unless accompanied by signed Release of Information.

Please attach W-10, discharge summary, and/or most recent assessment, if applicable.

SOUND COMMUNITY SERVICES, INC.

Authorization for Release of Information

Mandatory Release

Name:________________________________D.O.B.:_________________SSN:__________________

I understand that the information to be exchanged may contain protected substance abuse, psychiatric, and confidential HIV-related information (Protected Health Information).
I authorize Sound Community Services, Inc. to:

☐ ***Release*** Protected Health Information to: *and/or* ☐ ***Obtain*** Protected Health Information from:

____

Individual / Organization Name, Address

The Protected Health Information that may be used or disclosed includes: [Check all that apply]

☐ Complete Medical Record
☐ Admission Assessment
☐ Progress Notes
☐ Discharge Summary

☐ Mental Health Information
☐ Drug/Alcohol related information
☐ HIV/AIDS related information
☐ Medications

Approximate Episode of Care Dates:
☐ All Episodes
☐ Specific: _______________

☐ Other (specify):____ The information released under this authorization will be used for the following purposes: [Check all that apply]

☐ Assess for Intake Purposes
☐ Coordinate Care

☐ Provide Treatment
☐ Refer for Services

☐ Review History
☐ Other:_________

I understand this information will be used to provide comprehensive and coordinated services. I agree that a copy of this authorization will be as valid as the original. I understand this consent will expire as designated below, but in no case will it expire later than one year from the date of my signature. I give this consent freely and voluntarily and understand that refusal to grant authorization will not prevent me from utilizing services upon acceptance to Sound Community Services, Inc.

I understand that I may revoke this consent at any time prior to the release of the above information by making the request in writing to Sound Community Services, Inc. as indicated below, but that any such revocation will not apply to information already released. I understand that information, once disclosed to others, may be re-disclosed to entities not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and therefore, may no longer be protected by HIPAA.

The confidentiality of this record is required under chapter 899 of the Connecticut General Statutes as well as Title 42 of the Untied States Code. This material cannot be transmitted to anyone without your written authorization, as provided for in these statutes and described in detail in the Sound Community Services Privacy Notification.

____ ____

Signature of person served Date Staff Signature Date (or authorized representative)

**Note: If you are signing as the legal representative of the person served, please indicate your relationship: (This should demonstrate your authority to consent to health care for the person served)*

____

____

Expiration Date ***(Note: Release expires 1 year after the date signed by the person served unless otherwise noted here.)***

I,______________________________have decided to withdraw my authorization for Sound Community Services, Inc. to obtain or disclose protected health information to the above person, provider, or agency.

____ ____

Signature of person served Date Staff Signature Date (or authorized representative)

SOUND COMMUNITY SERVICES, INC.

Autorización para la divulgación de Información

Nombre:_______________________Fecha de Nacimiento_______________N.S.S________________

Entiendo que la información a intercambiar puede contener el abuso de sustancias protegidas, la información psiquiátrica y confidencial relacionada con el VIH/SIDA (información de salud protegida).

Autorizo a Sound Community Services, Inc. a:

☐ ***Emitir (****buscar) información de salud protegida para: y/o* ☐ *O**btener** información protegida de salud de:*

____

Nombre Individual/Organización, Dirección

La información de salud protegida que se puede utilizar o divulgar incluye: [Marque todas las que apliquen]

☐ Registro Médico completo	☐ Información sobre Salud Mental	Episodio aproximado de las fechas de cuidado:
☐ Evaluación de Admisión	☐ Información relacionada con Drogas y Alcohol	☐ Todos los Episodios
☐Notas de Progreso	☐ Información relacionada con el VIH/SIDA	☐ Específico: ________________________
☐Reporte de Alta Medico	☐ Medicamentos	

☐ Otros (especifiqué):____

La información publicada bajo esta autorización será utilizada para los siguientes propósitos:
[Marque todos los que apliquen]

☐ Evaluar para Propósito de admisión	☐ Proporcione el tratamiento	☐ Historia de la revisión
☐ Coordinación de Cuidado	☐Refiérase a los servicios	☐ Otros:__________________________
☐ Coordinación de Pago		

Entiendo que esta información se usará para proporcionar servicios integrales y coordinados. Estoy de acuerdo en que una copia de esta autorización será tan válida como el original. Entiendo que este consentimiento expirará como se indica a continuación, pero en ningún caso expirará más tarde de un año a partir de la fecha de mi firma. Doy este consentimiento libre y voluntariamente y entiendo que la negativa a otorgar la autorización no me impedirá utilizar los servicios a la aceptación de Sound Community Services, Inc.

Entiendo que puedo revocar este consentimiento en cualquier momento antes de la publicación de la información anterior, haciendo la solicitud por escrito a Sound Community Services, Inc. como se indica a continuación, pero que cualquier revocación no se aplicará a la información ya publicada. Entiendo que la información, una vez revelada a otros, puede ser revelada a entidades no sujetas a la Ley de Transferencia y Responsabilidad de Seguro Médico de 1996 (HIPAA), y por lo tanto, puede que ya no esté protegida por HIPAA.

La confidencialidad de este registro es requerido bajo el capítulo 899 de los Estatutos generales de Connecticut, así como el título 42 del código de Estados desatados. Este material no puede ser transmitido a nadie sin su autorización por escrito, según lo estipulado en estos estatutos y descrito detalladamente en la notificación de privacidad de Sound Community Services.

____ ____

Firma de la persona atendida Fecha Firma del Personal Fecha
(O representante autorizado)

**Nota: Si usted está firmando como el representante legal de la persona atendida, por favor indique su relación: (esto debe demostrar su autoridad para dar su consentimiento a la atención médica para la persona atendida)*

____

Fecha de Vencimiento ***(Nota: la fecha de espiración, es año después de la fecha firmada por la persona servida a menos que se indique lo contrario aquí.)***

Yo,____he decidido retirar mi autorización para Sound Community Services, Inc. para obtener o reveler información de salud protegida a la persona, proveedor o agencia mencionada arriba.

____ ____

Firma de la persona atendida Fecha Firma del Personal Fecha
(O representante autorizado)