



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 SCSJ 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 860-390-1459, thank you.

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

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]

- | | | |
|--|---|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Mental Health Information | Approximate Episode of Care Dates: |
| <input type="checkbox"/> Admission Assessment | <input type="checkbox"/> Drug/Alcohol related information | <input type="checkbox"/> All Episodes |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> HIV/AIDS related information | <input type="checkbox"/> Specific: _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medications | |
| <input type="checkbox"/> Other (specify): _____ | | |

The information released under this authorization will be used for the following purposes:

[Check all that apply]

- | | | |
|---|---|---|
| <input type="checkbox"/> Assess for Intake Purposes | <input type="checkbox"/> Provide Treatment | <input type="checkbox"/> Review History |
| <input type="checkbox"/> Coordinate Care | <input type="checkbox"/> Refer for Services | <input type="checkbox"/> 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 United 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 (authorized representative)	_____ Date	_____ Staff Signature	_____ Date (or
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**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)
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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 **Obtener** 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 (O representante autorizado)	Fecha	Firma del Personal	Fecha
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**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 revelar información de salud protegida a la persona, proveedor o agencia mencionada arriba.

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