Credo Community Center for the Treatment of Addictions, Inc.
Community Referral Form

Identifying Information:

Name:	Date of Birth:	Gender:
Address: Street/PO Box CITY, STATE, ZIP	Insurance Company:	
	Insurance Policy Number:	
	Social Security Number: - -	
	Home Phone Number: ( ) -	
	Cell Phone Number: ( ) -	
	Can we state agency name when calling? ☐ Yes ☐No	
Indicate any need for language/interpretation services; specify language spoken if other than English:	Race/ Ethnicity:	
	Marital Status:	
Reason for Referral:		

Referral Information:

Referral Source (Self, Probation, Parole, Physician, Etc.) If Physician, please send medical records/history of physical with/in past year	NYSID#: Release Signed: ☐YES ☐NO **Please provide NYSID Info and send release for ALL Criminal Justice Referrals
Referral Source Contact Information (Phone Number, Address, Contact person, Etc.)	NAME: PHONE: ( ) - , ext. ADDRESS: STREET/PO BOX CITY, STATE, ZIP
Emergency Contact (Name, Phone Number, Relationship, Etc.)	
Is this individual receiving additional services from other agencies? (Description of Services, Contact Name, Contact Number, Duration of Service, Etc.)	
Previous Treatment History (Details, Dates) Drug of	

Choice, Treatment Facility, Detox, Mental Health, Inpatient, Etc.)	
Drug of Choice (Drug, Date of Last Use, Frequency of Use, Etc.)	
Substance Abuse Diagnosis (DSM5)	☐N/A
Mental Health Diagnosis (DSM5)	☐N/A
Any history of IV needle use? If so, date last used.	☐N/A
Any chance of being pregnant?	☐N/A
Is this mandated treatment? (Court, Probation, Doctor)	
Does this individual have a primary care physician? If yes, please provide contact information.	
Does the individual have any chronic or acute medical conditions?	

Narrative

Provide any additional information that may be helpful to the clinician and Treatment Team assessing this individual.

Contact Information for Person Completing Referral:

Name:	Title:

Organization:	Address: STREET/PO BOX CITY, STATE, ZIP	County:
Phone: ( ) - ,ext. Fax: ( ) - ,	Email:	
Signature:	Date:	

PLEASE PROVIDE PATIENT'S BIOPSYCHOSOCIAL AND OTHER PERTINENT RECORDS

General Revoked on_____Staff Signature_____

CREDO COMMUNITY CENTER for the Treatment of Addictions, Inc.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____DOB:_____
Print full legal name

authorize the Credo Community Center to: **(x) disclose to** and/or **(x) obtain from**

_____**the following information**:
Print name

(HIV related information must be identified and described on a separate HIV specific release)

Yes	No	(check the appropriate items)	Yes	No	
( )	**( )**	**Involvement in program**	**( )**	**( )**	**Progress in treatment**
( )	**( )**	**Psychosocial evaluation**	**( )**	**( )**	**Medical Assessment /TB test results**
( )	**( )**	**Initial Determination Form**	**( )**	**( )**	**Discharge summary**
( )	**( )**	**Treatment plan/reviews**	**( )**	**( )**	**Recommendations**
( )	**( )**	**Alcohol/drug test results**	**( )**	**( )**	**Attendance**
( )	**( )**	**LOCADTR**	**( )**	**( )**	_____
( )	**( )**	**Financial Information**			**Specify information for release**
( )	**( )**	**DS-449**			

The purpose or need for such disclosure is:

( )	**Coordination of treatment**	**( )**	**Referral to** _____
( )	**Legal concerns**	**( )**	**Participation of family member in my treatment**
( )	**Probation / parole compliance**	**( )**	**To exchange information with my Medical Practitioner**
( )	**Insurance reimbursement**	**( )**	**Re-licensing DDP / DMV**
( )	**Court mandate**	**( )**	**Referral to medical practitioner for medical exam**
( )	**Social Services – SSI / SSD**	**( )**	**To process urinalysis sample**
( )	**Emergency contact**	**( )**	_____
( )	**Completion of evaluation**		
( )	**Re-disclosure of information obtained from:** _____		

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

This consent expires 1 year after the date of last contact unless otherwise checked below:

( )	**Six (6) months from the effective date**	**( )**	**One year from the effective date**
( )	**Upon completion of court mandate**	**( )**	_____

I understand that generally the Credo Community Center may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____

Signature of Client / Participant / Date **Signature of Parent / Legal Guardian / Date**

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2 and "HIPAA" 45 CFR Pts 160 & 164) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. General authorization for the release of medical or other information is NOT sufficient for this purpose. 6/1/06general