ROCHESTER
REGIONAL HEALTH

----- Patient Demographics -----

CHEMICAL DEPENDENCY INPATIENT REFERRAL FORM

Clifton Springs CD Inpatient
Phone: 315-462-3000
Fax: 315-462-7007

Unity& UMMC CD Inpatient
Phone: 585-723-7366
Fax: 585-723-7341

Patient Name: _____

Date of Birth: _____ SS#: _____

Patient Address: _____

Patient Phone Number: _____

Referral Source: _____Phone #_____

Insurance Type: _____ Policy#_____

Addiction

Diagnosis (Note: Please use ICD 10 codes with specifiers)

_____

Current CD Provider: _____ Start date in program: _____

Frequency (days per week) _____

Chemical Use disorder criteria:

1. Chemical use in physically hazardous situations
2. Social/interpersonal problems due to chemical use
3. Failure to fulfill work, school, home obligations due to chemical use
4. Tolerance
5. Withdrawal
6. Attempts to quit/control chemical use
7. Time spent obtaining, using and recovering from chemical use
8. Activities given up due to chemical use
9. Ongoing chemical use despite physical or psychological problems
10. Cravings or urges for chemical use
11. Taken in larger amounts or over a longer period of time than intended.

Substance	Age of First Use	Amount and Route/frequency	Criteria (Please indicate criteria from list above for each substance)	Last Use Date
Alcohol				
Cocaine/Crack				
Cannabis				
Opiates (Heroin / Pills) Method of Use: _____				
Other:				

Prior Chemical Dependency Treatment History:
Inpatient/Detox or Outpatient:

Provider	Dates	Completed?
		Yes ___No ___
		Yes ___No ___
		Yes ___No ___

Medical

Medical Problems: Yes ___ (list) No ____	Current Medications: (include Mental Health Meds)
Seizure History: Yes____ No____ Last Known Seizure:_____ Was seizure ETOH related: Yes___ No ___ **Does client have MRSA or ORSA:** Yes ____ No ____ Unknown _____	Compliant with Meds: Yes ____ No ____ If No is non-compliance related to chemical use: Yes ____ No ____

Has client been admitted to the hospital in the past 6 months for non- chemical abuse- related issues:
Yes ____ No ____

If yes, Date(s): _____
Describe: _____
_____

Mental Health

Is client currently engaged with a Mental Health Outpatient Provider? Yes ___ No ___
If yes, which facility/practitioner: _____
MH diagnosis: _____
Start date in current MH program: _____
Current MH concerns: (circle one) Suicidal Homicidal Hallucinations
Other: _____
Current Suicidal Ideations: Yes ___ No ___Current Homicidal Ideations: Yes__ No__
Suicidal Ideations within past 6 months: Yes _ No _ Comments: _____
Homicidal Ideations within past 6 months Yes_ No _ Comments: _____
Has client ever attempted suicide: Yes ___ No ___
Date of last known suicide attempt: _____ Describe: _____

Prior Mental Health Treatment History:

Outpatient		Inpatient	
Provider	Dates	Provider	Dates

Social

Marital/Relationship Status: _____
Current Living Situation: Alone___ Family ___ Non-related persons ___ Homeless ____
If living with Family or non-related persons, is this a sober environment: Yes ___ No ___
Is client currently being referred to a Community Residence (HWH): Yes ___ No ___
If yes, where: _____

Vocational/Educational

Level of education completed: _____
Is client currently employed: Yes ___ No ___
If yes, where and for how long: _____
Is client's use of substances impacting employment: Yes ___ No ___
Is yes, explain: _____

Legal

Does client have current legal charges: Yes ___ No ___
If yes, describe: _____
Is client currently on probation or parole (circle one): Yes ___ No ___
Describe charge: _____

Signature of Referral Source _____

Date:_____ Time:_____

Signature of Admission Coordinator:_____

Date Reviewed:_____ Time:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

ROCHESTER
REGIONAL HEALTH

Please review the below prior to completing the referral

Program referring to:

_____ Clifton Springs CD Inpatient
_____ Unity and UMMC CD Inpatient

Checklist:

_____ Completed referral form
_____ Consent for communication
_____ Current Medication list
_____ Most recent tox screens (if applicable)
_____ Completed LOCADTR
_____ Copy of PPD (if applicable)