**PROMOTING ACCESS TO HOPE** 

**PATH TEAM**

**REFERRAL FORM**

\*\*Please include attached ROI for care coordination\*\*

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name:  |  | Date of Referral: |  |
| Gender:  | Male ☐ Female ☐ Trans Male ☐ Trans Female ☐ Gender non conforming ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ |
| Race:  |  | Ethnicity: |  |
| DOB:  |  | Language preference | ☐English ☐ Spanish ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insurance Provider: | OHP ID: CCO:  | County of coverage (must be Multnomah unless Ryan White funded) |
| Phone number:  |  | Text ok? ☐ Email ok? ☐ email: | OK to leave a message? ☐ |
| **Reason For** **Referral:** |  |
| **Check all that** **apply:** | Veteran ☐ Pregnant ☐ IV use ☐ Child Welfare Involvement ☐ BIPOC ☐HIV+ ☐ LGBTQ+ ☐Other ☐ |
| Current/Recent Substance use: |  |
| Current Legal Involvement: |  |
| Housing status**:** |  |
| Hangout area? (eg. NE, SE, North, etc.) | ☐ North ☐ Northeast ☐ Inter Northeast ☐ Gresham ☐ Mid County, ☐ East of 82nd ☐ Downtown☐ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Write specific location (eg. under burnside bridge, dawson park, Union station, street corners etc.) |
| Any known medical/mobility needs: |  |
| Mental Health Diagnosis: |  |
| Recent ED Visits/Hospital admissions |  |
| SI History |  |
| Problem Gambling History in last year |  |

**PROVIDER INFORMATION OR REFERRAL SOURCE**

|  |
| --- |
| ☐Hospital ☐Unity ☐PCP ☐MITT ☐ TC911 ☐ Behavioral Health Provider ☐ DCJ Other ☐\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Agency Name: |  |
| Contact Name: |  |
| Phone: |  |
| Email: |  |
| Other Providers Involved: |  |

**ADDITIONAL INFORMATION**

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|  |

**\*\*\*\*\*\* Please email referrals to: \_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*\*\*\* For Ryan White referrals: rwabc@multco.us** Rev. June 2021





Individual’s Name: AKA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

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

Initial all that apply. I authorize the Mental Health and Addiction Services Division to:

\_\_\_ disclose health information to:

\_\_\_ receive health information from:

\_\_\_ verbally exchange health information with:

|  |  |
| --- | --- |
| Check any box that applies:**☒** My past, present and future treatment providers; **OR**☐ An intermediary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; **OR**☐ An individual/entity as specified: | Name of Individual/Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Person/Attention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State : \_\_\_\_\_\_\_\_\_ ZiP:\_\_\_\_\_\_\_\_\_Phone: Fax:  |
| Purpose: I authorize the exchange or disclosure of the health information for the following reasons:\_Coordination\_Care, Treatment, Payment, and Health Care Operations Activities, Case management\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Information to be exchanged or disclosed: ☒ All of my health information; or☐ Current medication records/medication list; and/or☒ The following health information:Substance use and Mental Health records including diagnosis, referral, treatment, and discharge information |
| By initialing the spaces below, I authorize the disclosure of the following health information, if such information exists:\_\_\_\_\_\_ Substance Use Disorder diagnosis, treatment or referral information \_\_\_\_\_\_ HIV/AIDS related records \_\_\_\_\_\_ Genetic testing information \_\_\_\_\_\_ Mental Health information |

I understand that my substance use disorder treatment records may be protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2) and cannot be re-disclosed without my written consent unless otherwise permitted or required by law. If I have named an intermediary, the intermediary may re-disclose my substance use disorder information to verified treating providers and I may request a list of re-disclosures directly from the intermediary.

I may revoke this authorization in writing at any time to any MHASD staff. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization.

I understand signing this authorization is not a condition to receive treatment, payment, or eligibility.

This authorization will expire in one (1) year or upon (insert date or event)

I understand what this authorization means and I am signing voluntarily.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Individual/Legal Guardian (circle one) Printed Name Date

Individual’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| Revocation: I no longer authorize the exchange or disclosure of my health information.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Individual/Legal Guardian (circle one) Printed Name Date/TimeSTAFF USE ONLY☐ Individual/legal guardian revoked verbally (phone or other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_MHASD Staff Member Signature/Credential Printed Name Date/Time |

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