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

SECTION 1: PROGRAM INFORMATION:

Which program/level of care is the current referral intended for?

Outpatient:

- ☐Mental Health
- ☐ Substance Use Disorder
- ☐ Integrated Outpatient Services (Mental Health & Substance Use Disorder)
- ☐ Opioid Treatment Program (Opioid Use Disorder)

Residential:

- ☐ Men's Community Residence
- ☐ Women's Intensive Residential
- ☐ Residential Rehabilitation for Youth

SECTION 2: CLIENT INFORMATION

First & Last Name	
Date of Birth (XX/XX/XXXX)	
Social Security Number (XXX-XX-XXXX)	
Gender at Birth	
Current Identified Gender	
Home Address (Street, City, State, Zip)	
Home County	
Phone Number (with area code)	
Insurance Company Name	
Insurance Policy Number	
Race/Ethnicity	
Marital Status	
Emergency Contact First & Last Name	
Emergency Contact Phone Number (with area code)	
Emergency Contact Relationship	

Can we state that we are calling from Credo when calling the phone number listed above?

☐ Yes
☐ No

Do you have a need for language/interpretation services?

☐ Yes - please specify _____
☐ No

SECTION 3: REFERRING ENTITY INFORMATION:

Is this a self-referral?

☐ Yes
☐ No – please complete the sections below

Entity Name **Please provide biopsychosocial, TB test results or other test results, any labs and physical within the past year**	
Referral Source Contact – First & Last Name	
Referral Source Contact - Phone Number (with area code)	
Referral Source Address (Street, City, State, Zip)	
Referral Source Email Address	
Is this mandated treatment (court, probation, doctor)? ☐ Yes ☐ No **NYS ID#:** **Release Signed** ☐ Yes ☐ No ****Please provide NYS ID Info and send release for ALL Criminal Justice Referrals**	
Is the client currently receiving additional services from other agencies? ☐ Yes – please specify (i.e., description of services, contact name & phone number, duration of service, etc.) ☐ No	

Previous Treatment History Please include dates, drug of choice, treatment facility/level of care (detox, mental health, inpatient, etc.)	
Individual's drug of choice Please include: • Name of Drug • Date of Last Use • Frequency of Use • Any other relevant information	
Substance Abuse Diagnosis (DSM5) ☐ Yes - please specify ☐ No	
Mental Health Diagnosis (DSM5) ☐ Yes - please specify ☐ No	
Any history of IV drug use? ☐ Yes - please indicated date last used ☐ No	
Any chance of being pregnant? ☐ Yes ☐ No	
Does this individual have a primary care physician? If yes, please provide contact information. ☐ Yes - please provide name and phone number ☐ No	
Does the individual have any chronic or acute medical conditions? ☐ Yes ☐ No	

Narrative

Please provide any additional information that may be helpful to the clinician and treatment team assessing this individual.

PLEASE PROVIDE PATIENT'S BIOPSYCHOSOCIAL AND OTHER PERTINENT RECORDS

Please submit this completed form and any relevant documentation/records via an ENCRYPTED EMAIL to: Referral@credocc.com

If you have any questions, please contact: (315) 788-1530

Credo Community Center for the Treatment of Addictions, Inc.
595 West Main Street • Watertown, NY 13601
Phone: (315) 788-1530 • Fax: 315-788-3794
referral@credocc.com

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)

Please check the appropriate items:

Yes	No		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**	☐	☐	**Pre-certification for admissions**
☐	☐	**LOCADTR**	☐	☐	**Other:** _____
☐	☐	**Financial Information**			
☐	☐	**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**	☐	**Other:** _____
☐	**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**	☐	**Two (2) years from last contact**

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