



# 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 Community Residence
- 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	

**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](mailto:referral@credocc.com)

**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

<p><b>Entity Name</b></p> <p><small>Please provide biopsychosocial, TB test results or other test results, any labs and physical within the past year</small></p>	
<b>Referral Source Contact – First &amp; Last Name</b>	
<b>Referral Source Contact - Phone Number (with area code)</b>	
<b>Referral Source Address (Street, City, State, Zip)</b>	
<b>Referral Source Email Address</b>	
<p><b>Is this mandated treatment (court, probation, doctor)?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p><b>NYS ID#:</b></p> <p><b>Release Signed</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p><small>**Please provide NYS ID Info and send release for ALL Criminal Justice Referrals</small></p>	
<p><b>Is the client currently receiving additional services from other agencies?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes – please specify (i.e., description of services, contact name &amp; phone number, duration of service, etc.)</li> <li><input type="checkbox"/> No</li> </ul>	

<p><b>Previous Treatment History</b></p> <p>Please include dates, drug of choice, treatment facility/level of care (detox, mental health, inpatient, etc.)</p>	
<p><b>Individual's drug of choice</b></p> <p>Please include:</p> <ul style="list-style-type: none"> <li>• Name of Drug</li> <li>• Date of Last Use</li> <li>• Frequency of Use</li> <li>• Any other relevant information</li> </ul>	
<p><b>Substance Abuse Diagnosis (DSM5)</b></p> <p><input type="checkbox"/> Yes - please specify</p> <p><input type="checkbox"/> No</p>	
<p><b>Mental Health Diagnosis (DSM5)</b></p> <p><input type="checkbox"/> Yes - please specify</p> <p><input type="checkbox"/> No</p>	
<p><b>Any history of IV drug use?</b></p> <p><input type="checkbox"/> Yes - please indicated date last used</p> <p><input type="checkbox"/> No</p>	
<p><b>Any chance of being pregnant?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p><b>Does this individual have a primary care physician? If yes, please provide contact information.</b></p> <p><input type="checkbox"/> Yes - please provide name and phone number</p> <p><input type="checkbox"/> No</p>	
<p><b>Does the individual have any chronic or acute medical conditions?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	

**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](mailto:Referral@credocc.com)

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

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	
<input type="checkbox"/>	<input type="checkbox"/>	Involvement in program	<input type="checkbox"/>	<input type="checkbox"/>	Progress in treatment
<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial evaluation	<input type="checkbox"/>	<input type="checkbox"/>	Medical Assessment /TB test results
<input type="checkbox"/>	<input type="checkbox"/>	Initial Determination Form	<input type="checkbox"/>	<input type="checkbox"/>	Discharge summary
<input type="checkbox"/>	<input type="checkbox"/>	Treatment plan/reviews	<input type="checkbox"/>	<input type="checkbox"/>	Recommendations
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/drug test results	<input type="checkbox"/>	<input type="checkbox"/>	Pre-certification for admissions
<input type="checkbox"/>	<input type="checkbox"/>	LOCADTR	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Financial Information			
<input type="checkbox"/>	<input type="checkbox"/>	DS-449			

The purpose or need for such disclosure is:

- |  |   |
|--|---|
| <input type="checkbox"/> Coordination of treatment                         | <input type="checkbox"/> Referral to _____                                    |
| <input type="checkbox"/> Legal concerns                                    | <input type="checkbox"/> Participation of family member in my treatment       |
| <input type="checkbox"/> Probation / parole compliance                     | <input type="checkbox"/> To exchange information with my Medical Practitioner |
| <input type="checkbox"/> Insurance reimbursement                           | <input type="checkbox"/> Re-licensing DDP / DMV                               |
| <input type="checkbox"/> Court mandate                                     | <input type="checkbox"/> Referral to medical practitioner for medical exam    |
| <input type="checkbox"/> Social Services – SSI / SSD                       | <input type="checkbox"/> To process urinalysis sample                         |
| <input type="checkbox"/> Emergency contact                                 | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Completion of evaluation                          |   |
| <input type="checkbox"/> 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:

- |   |   |
|---|---|
| <input type="checkbox"/> Six (6) months from the effective date | <input type="checkbox"/> One year from the effective date |
| <input type="checkbox"/> Upon completion of court mandate       | <input type="checkbox"/> 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
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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