Residential Care Referral

CONFIDENTIAL

Date Completed: ____________ Completed By: ____________

Application for (check one): ☐ Residential Services ☐ Family Treatment Homes ☐ Home-based Services

Program: ____________ Program: ____________ Program: ____________

Reason for Referral:

Goals for Treatment:

Referred Student: ____________

DOB: ____________ SS#: ____________

Ethnicity: ____________ ☐ Male ☐ Female

Current Placement: ____________

Contact Name: ____________

Contact Phone #: ____________

Most Current Psychiatric Diagnosis:		Code:
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		

Date of diagnosis: ____________

Diagnosed By: ____________

Mother's Name: ____________

Mother's Phone #: ____________

Mother's Address: ____________

City: ____________ State: ______ ZIP: ________

Father's Name: ____________

Father's Phone #: ____________

Father's Address: ____________

City: State: ZIP:

Referral Source:

Agency (if applicable): ____________

Contact Name: ____________

Contact Phone #: ____________

Is this person the legal guardian? ☐Yes ☐ No

If no, name of legal guardian: (or if not sole guardian,

name of other guardian): ____________

Insurance/Medicaid Information:

(If Medicaid, include Resource Code)

Insurance 1

Name: ____________ Number: ____________

Subscriber Name: ____________ SS#: ____________

Group Name: ____________ Number: ____________

Insurance Telephone #: ____________

Insurance 2

Name: ____________ Number: ____________

Subscriber Name: ____________ SS#: ____________

Group Name: ____________ Number: ____________

Insurance Telephone #: ____________

The following information should accompany this referral:

- ☐ Release of Information Form(s) - *Required*
- ☐ Custody Document (must be legal document)
- ☐ Psychological and/or Psychiatric Evaluations
- ☐ Disposition Report (if applicable)
- ☐ Discharge Summaries from Previous Placements and/or Treatment Plan Reviews (if applicable)
- ☐ Copy of School Records (for admission)
- ☐ Immunization Records and Physical (must have prior to admission for Residential Treatment only)
- ☐ Regional Placement Authorization

Child's Name:

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I voluntarily authorize the mutual exchange of clinical information between ____________________ and ____________________

- ☐ **Clinical Summary**
- ☐ **Continuing Care Plan**
- ☐ **Medical/Dental Aftercare Plan**
- ☐ **Intake Assessment**
- ☐ **Psychiatric Review(s)**
- ☐ **Neuropsychiatric Evaluation**
- ☐ **Psychological Assessment(s)**
- ☐ **Substance Abuse Assessment(s)**
- ☐ **Clinical and Laboratory Results**
- ☐ **Consultations**
- ☐ **Discharge Summary**
- ☐ **Immunization Records**
- ☐ **Medical History/Physical Exam**
- ☐ **Special Education Records**
- ☐ **Verbal exchange of all information to aid in assessing and/or treating student.**
- ☐ **Other:** ____
- ☐ **Physician Orders**
- ☐ **Progress Notes**
- ☐ **Psychiatric Assessment(s)**
- ☐ **Treatment Plan & Needs Sheets**
- ☐ **Treatment Plan Review(s)**
- ☐ **UA Results**

This information is being released/requested for the following purpose:

☐ **Legal Request** ☐ **Further Treatment** ☐ **Insurance Claim** **Other:**

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of this information to investigate or prosecute any alcohol or drug abuse patient.

Disclosure of patient information is permitted with the patient's written consent; however, disclosures to central registries and in connection with criminal justice referrals must meet the following specific regulations: (42 CFR 2.32 and 2.33) This information disseminated from ____________________

In addition, health care information that has been disclosed toyou under this agreement is protected by the Health InsurancePortability and Accountability Act (HIPAA). As such any further disclosure of health care information provided is subject toHIPAA privacy and security regulations.

This information may be used for continuation of care. I understand this authorization will expire on: __________________ or, if the child is accepted, *6 MONTHS FOLLOWING THE DATE OF DISCHARGE FROM* ___________________, revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photostatic and/or facsimile copies of this authorization will be considered as valid as the original.

I acknowledge that the information to be released is protected by Federal law and may include information regarding drug/alcohol abuse, sexually transmitted diseases/HIV and/or Hepatitis B. My signature below authorizes the release of this information.

____
Student ***Date***

____
Parent ***Date***

____
Guardian/Placing Worker/Legal Representative ***Date***

____
Witness ***Date***

PLEASE RETURN FORM TO:

Presbyterian Hospitality House
209 Forty Mile Avenue, Suite 100
Fairbanks, AK 99701

ATTN: **Ty Tigner, Program Director**
FAX: **907-456-6402**
TEL: **907-456-6445**

☐ **Approved** ☐ **Denied** **Reason for denial:** ______________________________

Signature of Representative for the facility ***Printed name*** ***Date***

Student Name:	Student Number:	Student DOB: