CASA

TRINITY

CASA-Trinity Clinical Referral

Please attach: 1. Current LOCADTR, 2. Current Assessment, 3. Physical exam within 12 months (if available) 4. Current Medication List

Fax to: (585) 335-5061

Referral for (circle one of the following): Medically Supervised Detox 28-day inpatient 820 Residential

IDENTIFYING INFORMATION			
Patient Name:	**Date:**	**Contact Phone:**	
Gender: ☐M ☐F ☐TG	**Social Security #:**	**DOB:**	**Age:**
Address:	**City:**	**State:**	**Zip:**
Is the Patient? ☐ An IV user ☐ Pregnant ☐ Parent of a child at risk of Foster Care placement ☐ Homeless			**Is the patient a risk to others?** ☐ Yes ☐ No
Marital Status: (check one) ☐Single ☐Married ☐Partner ☐Separated ☐Divorced ☐Widowed			
PATIENT Insurance ID #:		**Diagnosis**	**If Inpatient/Incarcerated**
☐ Medicaid ☐ Managed Care ☐ Medicare ☐ Commercial ☐ Private Pay	***Department of Social Services (DSS)*** ☐SNAP ☐General Assistance ☐ None	**DSM V**	**Date of anticipated discharge from your program.**

Complete LOCADTR	Please attach LOCADTR
LOCADTR Results	
Why does your client need level of care they are being referred to?	

	Printed Name	Agency	Date
Completed by:			
Contact Info	**Phone/Fax**	**Email**	**County**
	Client Attestation	**Signature**	**Date**
	I understand that I'm being referred to a residential program. I also attest that the information above is true and correct.		

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Release of Information

I, (client name) ____ (D.O.B.) ________________, hereby authorize CASA-Trinity to exchange information with:

Referring Agency:
Agency Address:
Agency Phone:

EXTEND OR NATURE OF INFORMATION TO BE DISCLOSED:
( ) Lab results
( ) Diagnosis
( ) Evaluations/Assessments
( ) History and Physical
( ) Treatment Plan/Updates
( ) Discharge Summary
( ) PPD. Results
( ) Demographics
( ) Other: _____________________

PURPOSE OR NEED FOR DISCLOSURE/RELEASE:
( ) Admission
( ) Disability information
( ) Continuity of Care
( ) Legal
( ) Job Related
( ) Insurance Reimbursement
( ) Emergency Contact
( ) Other: _________________________

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility names to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event, or condition is specified below, in which case such time period, event, or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations Part 2 governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 45 C.F.R. Pts. 160 & 164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event, or condition replacing period specified above: ______________________.
By signing this form, I acknowledge that I have been offered a copy of this document and **ACCEPTED/REFUSED** the copy.

_____________ ______________________________________
Date Client Signature

_____________ ______________________________________
Date Witness Signature