Restore House Inc - Client Referral Form

Client Name: ______________________________________ **Phone#:**__________________ **Admit Date:** _________________

DOB: ____________________ **Assigned House:** _______________________ **Assigned ADC** ____________________________

SSN: ________________________ **Level of TX Recommended: High:** ____**Med:** ____**Days:** _______ **Code:** _______________

Funding County: _________________________ **Insurance Type:** _________________________**Ins#/PMI:** ________________

Funding Case Mgr: ___________________________________ **Phone:** ____________________ **Fax:** _____________________

Rule 25 Assessor: _____________________________________ **Phone:** ____________________ **Fax:** _____________________

Corrections Agent: ___________________________________ **Phone:** ____________________ **Fax:** _____________________

Public Defender/Attorney: _____________________________ **Phone:** _____________________ **Fax:** ____________________

Health/ Medical Info:

Current Medications____

Mental Health Diagnosis: ____

Current Physician: ____

Present Medical Concerns: ____

Allergies: Yes_____ **No**______ **If yes, list:**____

Need to apply for Insurance YES ____ **NO** _____

Interview/Other Information for ITP purposes:

Rule 25 Completion Date: ____

Financial/Income Situation: ____

Housing Situation: ____

Drug(s) of Choice: ____

Last Date of Use: ___________________________________ **Need for Detox: Yes** _____ **No**_____

Possess Photo Identification: Yes_____ **No**______

Prior Treatment Programs & Dates____

____

What led to your current relapse: ____

____

How did you become interested in the Restore House Treatment Program: ____

____

Household Size: ___ **Marital Status: (Circle One) D L M N S U W**

Marital Status = D - Divorced, L - Legally separated, M - Married, N - Never Married, S - Living apart, U - Unknown, W – Widowed

Completing Form: ___________________________**Title:** ___________________________________ **Date:** __________

RESTORE HOUSE INC.
Residential Treatment Facility
CONSENT FOR RELEASE OF INFORMATION

3007 Birchmont Dr NE
Bemidji, Minnesota 56601
Phone: 218-444-9420

P.O. Box 1191
Bemidji, MN 56619-1191
Fax: 218-444-9212

1001 Mississippi Ave. NW
Bemidji, MN 56601

Name: (Last)________________________________(First)______________________(M.I.)_________

Phone: (_________) ____________________ Birthdate: ________________

I hereby do give consent and authorize: Restore House Inc

__X__To release information to:

__X__Obtain information from:

Company/Individual Name: Probation Agent

Address: ____

City: ______________________________ State: __________Zip: ___________

Phone: ____________________ Fax: ____________________

Information can be communicated __X Verbally, X Written, and/or_X___ Facsimile.

I understand the purpose of this release is to facilitate the assessment, treatment planning, and discharge planning regarding the client who has accessed the Restore House Inc. for treatment services.

I understand the specific information to be disclosed includes information on the items with an "x" below:

_X_ Discharge Summary
_X_ Chemical Dependency Evaluation
_X_ Progress in Treatment/Progress Notes
_X_ Acknowledgement of Client's access of service
_X_ History and Physical
_X_ Doctor's consult results
_X_ Assessment/Admission Intake
_X_ Treatment Plan/Recommendations
_X_ Lab: Urine Drug Screens
_X_ Psychological/Psychiatric Consults
_X_ Communication
___ Other: ___________________________

Effective this date __________ to expire ___________ unless revoked by me.
NOTE: This authorization, except for action already taken, can be revoked at any time.

NOTICE: Further disclosure of confidential information without the specific written consent of the person to whom it pertains is prohibited by state and federal statutes.

NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: This information has been disclosed to you from records protected by Federal Confidentiality Rules 42 CFR Part 2. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that information in confidential records cannot be released without my written consent unless otherwise provided for in legal statutes and judicial orders. If I choose to revoke this consent I understand that I must submit a written request to the Administrative office. However, I understand that a residential Treatment organization cannot take back information that has already been released in response to this authorization. I understand that the revocation of this authorization will not apply to my insurance company whenever my insurer has the legal right to contest any claims. My signature below indicates that I understand the conditions of this release and that I give my authorization voluntarily.

SIGNATURE: ____**DATE:**____________________

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Name: (Last)________________________________(First)_______________________(M.I.)_________

Phone: (_________) ____________________ Birthdate: ________________

I hereby do give consent and authorize: Restore House Inc

__X__To release information to:

__X__Obtain information from:

Company/Individual Name: Rule 25

Address: ____

City: ______________________________ State: __________Zip: ____________

Phone: ____________________ Fax: ______________________

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- _X_ Assessment/Admission Intake
- _X_ Treatment Plan/Recommendations
- _X_ Lab: Urine Drug Screens
- _X_ Psychological/Psychiatric Consults
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Name: (Last)______________________________(First)______________________(M.I.)_________

Phone: (_________) ________________________ Birthdate: __________________

I hereby do give consent and authorize: Restore House Inc

__X__To release information to:

__X__Obtain information from:

Company/Individual Name: Restore House Treatment Team

Address: 3007 Birchmont Dr NE __City: Bemidji State: MN _______Zip: 56601

Phone: 444-9420______ Fax: **444-9420**

Information can be communicated __X Verbally, X Written, and/or__X__ Facsimile.

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