Referral Form

Type in the shaded fields, save, then fax to (605) 401-4086 or send by encrypted email to HouseShalom@thebecomingagency.com. The client should know you are referring them.

DATE OF REFERRAL | **CLIENT NAME** | **DATE OF BIRTH**

CLIENT PHONE

CONTACT PREFERENCES AND TRACK

☐ OK to text ☐ OK to leave a voicemail ☐ Adult (18+) ☐ Teen (13–17)

IF TEEN: PARENT OR GUARDIAN | **PARENT OR GUARDIAN PHONE**

REFERRED BY | **AGENCY**

YOUR PHONE | **YOUR EMAIL**

YOUR ROLE

☐ Court or probation ☐ Parole ☐ School ☐ Physician or prescriber ☐ Therapist or clinic ☐ Hospital or detox
☐ Employer ☐ Church or ministry ☐ Family ☐ Self ☐ Other

REASON FOR REFERRAL

SUBSTANCES OF CONCERN

CURRENT MEDICATION FOR ADDICTION TREATMENT

☐ None ☐ Buprenorphine ☐ Methadone ☐ Naltrexone ☐ Other

OTHER MEDICATION / PRESCRIBER | **RECENT DETOX, INPATIENT OR RESIDENTIAL (WHERE, WHEN)**

SAFETY CONCERNS WE SHOULD KNOW ABOUT

ASSESSMENT

☐ Current assessment attached ☐ Please schedule an assessment

DATE OF ATTACHED ASSESSMENT | **INTENDED TREATMENT START DATE**

LEVEL OF CARE YOU ARE RECOMMENDING

☐ 2.1 IOP ☐ 1.0 outpatient ☐ Not sure, please assess

JUSTICE INVOLVEMENT

☐ Court-ordered or required ☐ Leaving jail or another facility ☐ On probation or parole

DEADLINE OR NEXT COURT DATE | **FACILITY** | **RELEASE DATE**

PROBATION OR PAROLE OFFICER | **SUPERVISION START DATE**

PAYMENT

☐ SD Medicaid ☐ Private insurance ☐ Uninsured ☐ Not sure

INSURANCE PLAN

CLIENT CONSENT TO CONTACT

☐ The client has agreed to be contacted by House Shalom

Information you send us about a client is held in confidence. We can report back to you only if the client signs a release that names you.

House Shalom · The Becoming Agency · 3409 W. 47th Street, Suite 102, Sioux Falls, SD 57106

Release of Information · Referral Partner

Consent for Release of Confidential Information · 42 CFR Part 2 § 2.31

For physicians, clinicians, schools, employers, churches and family. For a court, probation, parole or other legal purpose, use the Criminal Justice Release instead; federal rules don't allow the two purposes on one form. Signatures must be handwritten or a valid electronic signature.

CLIENT NAME | **DATE OF BIRTH**

I authorize **House Shalom / The Becoming Agency**, 3409 W. 47th Street, Suite 102, Sioux Falls, SD 57106, to disclose to and receive from:

NAME | **ORGANIZATION**

ADDRESS | **PHONE / FAX**

THE FOLLOWING INFORMATION

☐ Attendance and enrollment verification ☐ Treatment summary or progress report ☐ Discharge summary
☐ Treatment plan ☐ Assessment results ☐ Medication information ☐ Drug screening results ☐ Other

OTHER INFORMATION

FOR THIS PURPOSE

☐ Continuity of care and treatment coordination ☐ Insurance or billing ☐ Employment ☐ Family communication
☐ School coordination ☐ Other

OTHER PURPOSE

CONDITIONS OF THIS CONSENT

1. My records are protected under 42 CFR Part 2 and cannot be disclosed without my written consent unless a legal exception applies.
2. **Prohibition on redisclosure.** Federal law (42 CFR Part 2) prohibits the recipient from making any further disclosure unless 42 CFR Part 2 specifically permits it. Each disclosure will include the statement: "42 CFR Part 2 prohibits unauthorized use or disclosure of these records."
3. **Right to revoke.** I may revoke this consent at any time by submitting a written revocation to the Program Director at the address above. Revocation is effective upon receipt, except to the extent the program has already acted in reliance on this consent.
4. **Expiration** as marked below.
5. Each disclosure made under this consent will include a copy of this consent or a clear explanation of its scope.
6. I may refuse to sign this consent. My treatment, payment, enrollment or eligibility for benefits will not depend on whether I sign.

THIS CONSENT EXPIRES

☐ On a date ☐ Upon an event ☐ At the end of treatment ☐ Upon revocation

EXPIRATION DATE OR EVENT

CLIENT SIGNATURE | **DATE**

WITNESS SIGNATURE AND CREDENTIALS | **DATE**

For a client 13–17: the teen's own signature authorizes this release. A parent or guardian's signature is not consent to disclose and gives no access to the teen's records.

Release of Information · Criminal Justice

Consent for Disclosure to Criminal Justice or Investigative Entities · 42 CFR Part 2 §§ 2.31, 2.35

A standalone consent. Under 42 CFR Part 2, consent to use or disclose substance use treatment records in a civil, criminal, administrative or legislative investigation or proceeding cannot be combined with consent for any other purpose. Signatures must be handwritten or a valid electronic signature.

CLIENT NAME | **DATE OF BIRTH**

I authorize **House Shalom / The Becoming Agency**, 3409 W. 47th Street, Suite 102, Sioux Falls, SD 57106, to disclose the following information from my SUD treatment records to:

NAME / AGENCY

ADDRESS | **PHONE / FAX**

INFORMATION TO BE DISCLOSED

☐ Attendance and enrollment verification ☐ Treatment compliance reports ☐ Drug screening results
☐ Treatment summary or progress ☐ Discharge summary ☐ Other

OTHER INFORMATION

PURPOSE (CHECK ONE)

☐ Probation or parole supervision ☐ Court-ordered reporting ☐ Pre-sentence investigation
☐ Civil investigation or proceeding ☐ Criminal investigation or proceeding ☐ Administrative investigation or proceeding
☐ Other

OTHER PURPOSE

CASE OR DOCKET NUMBER | **REFERRING OFFICER OR JUDGE** | **JURISDICTION**

CONDITIONS

1. This consent is subject to all conditions of 42 CFR §§ 2.31 and 2.35.
2. **Redisclosure prohibition.** 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.
3. **Duration (§ 2.35(b)).** This consent remains in effect until the date or event below, a period set by the expected length of my treatment, the type of proceeding, the need for the information, and when final disposition is expected.
4. **Revocation (§ 2.35(c)).** If my treatment is a condition of a criminal justice disposition (box checked below), this consent becomes revocable only on the date or event below, which is no later than the final disposition of that release, probation, parole or proceeding. After that point, or if the box is not checked, I may revoke this consent in writing to the Program Director; revocation is effective upon receipt, except to the extent the program has already acted in reliance on it.
5. Each disclosure will include a copy of this consent or a clear explanation of its scope.
6. My treatment will not depend on whether I sign this consent.

CONSENT REMAINS IN EFFECT UNTIL (DATE) | **OR UNTIL THIS EVENT**

CONDITION OF DISPOSITION

☐ My treatment is a condition of a criminal justice disposition (probation, parole, sentence, diversion or release)

BECOMES REVOCABLE ON (DATE) | **OR UPON THIS EVENT (NO LATER THAN FINAL DISPOSITION)**

CLIENT SIGNATURE | **DATE**

WITNESS SIGNATURE AND CREDENTIALS | **DATE**