Hooper Culturally Specific Community Partner Referral Form

- Admission slots for our culturally specific partners will be available Tuesday, Wednesday and Thursday.
- Our goal is to have 1-2 slots available on those days to be rotated between our community partners.
- You can contact us before 10am Tuesday-Thursday to see if there are open beds for that day.

Referring providers: please fill out the attached items and email the completed forms to: HooperReferrals@ccconcern.org. A care coordinator will respond within 48 hours to the referral by contacting the patient directly to set-up the appointment. This applies when not using the process listed above.

- We require a ten-day supply of medications in the original package (including insulin and inhalers).
- Controlled substances such as Suboxone, Librium, Ativan, Ambien, Adderall, barbiturates, and Lyrica are not allowed in our facility. Please do not bring controlled substances unless the intent is to destroy them.

Contact Information

Please attach an ROI – without one we cannot process the referral.

Patient Phone Number:

Referring Agency:_____**Phone Number:** _____

Contact Person for Referral: _____

Is there a Discharge Plan in Place? □ Yes:_____ □ No □ Unknown

Discharge Agency:_____**Phone #:**_____

Contact Person for Discharge Planning:_____

Patient Information

Legal Name: _____ **Date of Birth:** _____

Preferred Name: _____

Race/Ethnicity: □ Alaskan Native □ American Indian □ Black and African American
□ Caucasian □ Asian □ Native Hawaiian □ Pacific Islander □ Hispanic □ Latino-A-X
□ Decline to Answer

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

Hooper Culturally Specific Community Partner Referral Form

Gender: □ Female □ Male □ Trans Female/Trans Woman/Affirmed Woman
□ Trans Male/Trans Man/Affirmed Man □ Genderqueer/Gender Non-Conforming
□ Agender/Without Gender □ Declined □ Additional Category: _____

Is the patient pregnant? □ Yes □ No □ Unknown

Which pronouns do they go by? □ She/Her □ He/Him □ They/Them
□ Don't Know/Decline to answer

Substance Use History and Medical Information

What substances are being used regularly (within the last 3 days)?

_____

_____

Is there daily use of the above substances? □ Yes □ No

Date of last use? _____

Any medical conditions or recent hospitalizations? □ Yes □ No □ Unknown

If yes, please list here:

_____

Any mental health issues, or recent hospitalizations due to mental health:
□ Yes □ No □ Unknown

If yes, please list here:

_____

CENTRAL CITY CONCERN
HOMES HEALTH JOBS
Administrative Headquarters
232 NW 6th Ave.
Portland, Oregon 97209
503-228-4533
Fax: 503-228-4618

FOR STAFF USE	Client Name .
	Client Date of Birth .
	EMR ID # .
	Telephone # .
	Yardi Tenant ID # .
FOR CLIENT USE	Other Names You Use .
	Pronouns .

External Authorization to Use and Disclose Protected Health Information

All Sections of This Form Must Be Completed or the Authorization Will Not Be Accepted

I authorize the following Central City Concern entities:

☐ **Central City Concern – Andrew Mendenhall, Chief Executive Officer, including CCC Health Services, CCC Housing and CCC Employment, or**

☐ Other _____

to receive and disclose a copy of the specific health information described below:

☐ All Medical Information **OR** ☐ Other (be specific):

_____

_____

to and from:

_____
(name of entity/facility)

_____
(address of entity/facility)

_____ _____
(telephone of entity/facility) (fax of entity/facility)

_____
(relationship to client/patient)

for the following purpose(s):

☐ Care Coordination ☐ Emergency contact ☐ Family/friend ☐ Legal

☐ Other _____

I understand that additional laws relating to use and disclosure may apply to the specific types of records or information listed below. My initials below authorize use and disclosure of these records or information as part of this authorized release of records:

PLEASE INITIAL EACH LINE

_____ **Mental Health Information**
_____ **Drug/Alcohol diagnosis, treatment, or referral information**
_____ **HIV/AIDS information**
_____ **Genetic Testing information**

I understand that I have the right to withdraw this authorization at any time by written notice. I understand that if I choose to withdraw this authorization, it will no longer be valid except to the extent that CCC has already acted in

reliance on the authorization. I understand that my health care and payment for that health care is not based upon whether I sign this authorization.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, if permissible by law, and will no longer be protected.

This authorization becomes effective on the date below, and will expire 24 months from my last day of service at Central City Concern, a period reasonably needed to complete the disclosure of information for the purposes described.

Client Signature: _____ **Date:** _____

OR

Representative Signature: _____ **Date:** _____

Representative's Relationship to Client:

Revocation of Authorization

By signing below, I hereby *revoke* (withdraw) this authorization to use and release protected health information.

Client signature to revoke consent: _____

Printed name: _____

Date consent revoked: _____