



## 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



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**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)?**

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**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:

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**Any mental health issues, or recent hospitalizations due to mental health:**

Yes  No  Unknown

If yes, please list here:

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Client Name	.
Client Number	.
Client Birthdate	.
Telephone Number	.

**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 CCC entity:

Hooper Detoxification Stabilization Center	
(name of CCC entity/facility)	
1535 N. Williams Ave., Portland, OR 97227	
(address of CCC entity/facility)	
503-238-2067	503-238-2004
(telephone of CCC entity/facility)	(fax of CCC entity/facility)

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

\_\_\_\_\_ (name of client/patient)

consisting of:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> All health information | <input type="checkbox"/> Medication orders    | <input type="checkbox"/> Presence in treatment     |
| <input type="checkbox"/> Discharge summary      | <input type="checkbox"/> Assessment           | <input type="checkbox"/> Treatment plan/progress   |
| <input type="checkbox"/> UA results             | <input type="checkbox"/> Labs                 | <input type="checkbox"/> Medication administration |
| <input type="checkbox"/> Progress notes         | <input type="checkbox"/> Other specify: _____ |  |

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:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Emergency contact   | <input type="checkbox"/> Continued care | <input type="checkbox"/> Family/friend |
| <input type="checkbox"/> Disability  | <input type="checkbox"/> School entry   | <input type="checkbox"/> Legal         |
| <input type="checkbox"/> Other, specify: payment, eligibility, enrollment, reporting, auditing, and intra-agency care coordination |   |  |

by means of:

- All forms of communication (verbal, written, electronic, and other)  
 Verbal only       Other, specify: \_\_\_\_\_

My initials below authorize the inclusion of the following information as part of this authorized release of records:

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | HIV/AIDS information                                       |
| <input type="checkbox"/> | Mental health information                                  |
| <input type="checkbox"/> | Genetic testing information                                |
| <input type="checkbox"/> | Drug/alcohol diagnosis, treatment, or referral information |

I understand that I have the right to revoke this authorization, at any time, provided that I do so in writing, and provided it is directed to the entity responsible for completing the release of information detailed in this document. If I choose to revoke this authorization, it will no longer be used for the reasons covered by this authorization. I understand that disclosures made prior to revoking this authorization cannot be rescinded. I understand that I do not have to sign this authorization. I understand that if I choose not to sign this authorization, my health care and payment for that health care cannot be conditioned upon receipt of this authorization and will not be affected.

This authorization becomes effective on the date below, and **will expire 12 months from my last day of treatment at Central City Concern**; a period reasonably needed to complete the disclosure of information for the purposes described and named within this authorization and named within this release **unless I indicate otherwise**:

Specific Expiration Date: \_\_\_\_\_

I have reviewed and understand this authorization. I also understand that the health or health-related 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 under the appropriate federal and/or state regulations pertaining to the information released herein. If the information released contains alcohol and chemical dependency diagnosis and/or treatment records, the records are further protected by federal confidentiality rules (42 CFR, Part 2). The federal rules prohibit further disclosure of this information unless I expressly permit the disclosure by written authorization or as otherwise permitted by 42 CFR, Part 2. A general release of medical or other information is NOT sufficient. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

By:	(client/patient signature)	(date)
By:	(client/patient representative signature)	(date)
Witnessed by:	(witness signature)	(date)

**Revocation of Authorization**

**By signing below, I hereby revoke this Authorization to Use and Release Protected Health Information.**

Client/patient signature revoking consent: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date consent revoked: \_\_\_\_\_

OPTIONAL: For administrative use only:

Records request submitted: \_\_\_\_\_ (date)

Records sent: \_\_\_\_\_ (date)

For file only \_\_\_\_\_