



Hooper DSC Referral Form

Appointments are available Monday through Friday with slots available between 8:00 AM and 1:00 PM. We ask that patients arrive 30 minutes early.

- 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.
- Please call or email if you're unsure what to bring. You may bring T-shirts, undergarments, books and journals.

Referring providers, please fill out the attached items and email the completed forms to: HooperReferrals@ccconcern.org. A staff member will call you to schedule an appointment. You must speak with the Hooper admissions team to confirm appointment availability. If they do not schedule you into a slot, you do not have an appointment.

Contact Information

We will call you and the client back to schedule the appointment within 48 hours of receiving the referral. 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: _____

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: _____

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

Is the patient pregnant? Yes No Unknown



Hooper DSC Referral Form Substance Use History and Medical Information

What substances are being used regularly?

Is there daily use of the above substances? Yes No

Have they used in the last 48 hours? Yes No

How long have they been using without a break? _____

Any Medical Conditions? Yes No Unknown

If yes, please list here:

Any Mobility Issues (i.e. wheelchair, walker, cane): Yes No Unknown

If yes, please list here:

Any Mental Health issues: Yes No Unknown

If yes, please list here:

Please list all current medications:

Name of Medication or Supplement	Dose, if known	Times/day



FOR STAFF USE	Client Name
	Client Date of Birth
	EMR ID #
	Telephone #
FOR CLIENT USE	Yardi Tenant ID #
	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.

 **SIGN HERE**

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: _____