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

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

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

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

Administrative Headquarters
232 NW 6th Ave.
Portland, Oregon 97209
503-294-1681

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 (telephone of CCC entity/facility)
503-238-2004 (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:

- ☐ All health information
- ☐ Discharge summary
- ☐ UA results
- ☐ Progress notes
- ☐ Medication orders
- ☐ Assessment
- ☐ Labs
- ☐ Other specify: .
- ☐ Presence in treatment
- ☐ Treatment plan/progress
- ☐ Medication administration

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:

- ☐ Emergency contact
- ☐ Disability
- ☐ Continued care
- ☐ School entry
- ☐ Family/friend
- ☐ Legal
- ☐ 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:

- _____ HIV/AIDS information
- _____ Mental health information
- _____ Genetic testing information
- _____ 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 _____