

 **Treatment Referral**

|  |
| --- |
| **REFERRING AGENCY** |
| **AGENCY** |  | **PHONE** |  |
| **LOCATION** |  | **EMAIL** |  |
| **FORM COMPLETED BY** |  | **PHONE** |  | **DATE** |  |

|  |
| --- |
| **RECEIVING AGENCY** |
| **AGENCY** | **For Hope’s Sake, LLC** | **PHONE** | **443-990-1824** |
| **LOCATION** |  | **EMAIL** | **referrals@4hopessake.org** |

|  |
| --- |
| **CLIENT INFORMATION** |
| **LAST NAME** |  | **FIRST NAME AND MI** |  |
| **DATE OF BIRTH** |  | **FEMALE / MALE** |  |
| **MA #** |  | **SOCIAL SECURITY #** |  |
| **INTERPRETER REQUIRED?** |  | **LANGUAGE REQUIRED** |  |
| **GUARDIAN NAME** |  | **GUARDIAN RELATIONSHIP** |  |
| **PATIENT’S ADDRESS** |  | **CELL PHONE** |  |
|  | **HOME PHONE** |  |
|  | **WORK PHONE** |  |
|  | **EMAIL** |  |
| **REFERRAL DIAGNOSIS** |  | **Drug of Choice?** |  |

|  |
| --- |
| **SERVICE REQUESTED** |
| **IS CLIENT RECEIVING MAT? OR INTEREST, IF SO, WHAT?** |
| **REASON FOR REFERRAL** |  |
| **PATIENT AWARE OF REASON FOR REFERRAL? IF NOT, PLEASE EXPLAIN.**  |  |
| **SERVICE / SPECIALTY REQUESTED** |  |

|  |
| --- |
| **CONSENT TO RELEASE INFORMATION** Read with client / caregiver and answer any questions before obtaining signature. |
| The signature below serves to authorize that the client understands that the purpose of the referral and disclosure of information to the agency listed above is to ensure the safety and continuity of care among service providers seeking to serve the client. The referring agency has clearly explained the procedure of the referral to the client and has listed the exact information that is to be disclosed. By signing this form, the client authorizes this exchange of information.  |
| **CLIENT SIGNATURE** |  | **CAREGIVER SIGNATURE** |  | **DATE** |  |

|  |
| --- |
| **DETAILS OF REFERRAL** |
| **ANY CONTACT OR OTHER RESTRICTIONS?** |   | **YES** |  | **NO** | **IF YES, EXPLAIN** |  |
| **REFERRAL DELIVERY METHOD** |  | **DATE** |  | **EXPECTED FOLLOW-UP METHOD** |  | **BY DATE** |  |