Sweetser ***Sweetser 50 Moody Street, Saco, ME 04072 1-800-434-3000***

REFERRAL REQUEST FORM

Referent: _____ Phone Number: _____ Date: _____

Facility/Provider: _____

Patient Information:

Male___ Female___ Other _____ Pronouns: _____ DOB: _____ SS#: _____

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ State/Zip Code: _____

Primary Phone: _____ Phone Type: Cell / Home Permission to Text: Y / N

Email: _____ Permission to Email: Y / N

Parent/Guardian: _____ Phone: _____

For Children – What School do they attend: _____

Additional Info:

Race: _____ Ethnicity: _____ Language: _____

Military: Y / N Employed: Y / N Class Member: Y / N Marital Status: _____ Consent to Telehealth: ☐

Services Requested:

Reason for Referral: _____

Services Requested: _____

Current Diagnosis: _____

Who/Where/When Diagnosis completed (*Include assessment w/referral*):_____

_____

Primary Care Provider:

Physician/NP: _____

Address: _____ State/Zip Code: _____

Phone: _____ Fax: _____

Insurance Information:

Insurance: _____

Insurance ID#: _____ Group #: _____

Insurance Holders Name: _____ DOB: _____
If different from patient

Medicare #:_____ MaineCare #:_____

Please fax to Sweetser PromiseLine 207-294-4691 or Email to: AccessCoordinator@sweetser.org

Sweetser
Promising Futures
Mental Health Recovery Education

DOCUMENTATION OF DIAGNOSIS

Client Name: _____
(First Name, MI, Last Name)

DOB: _____
(MM/ DD / YYYY)

Please fax documentation to:

Clinician Name:

FAX number:

DIAGNOSIS INFORMATION

Please complete with full detail.

Primary Diagnosis
Name/Description:

Diagnostic Code: *(check one):* ☐ ICD-10 (preferred) ☐ DSM-5

Date of diagnosis:

Secondary Diagnosis
Name/Description:

Diagnostic Code: *(check one):* ☐ ICD-10 (preferred) ☐ DSM-5

Date of diagnosis:

Tertiary Diagnosis
Name/Description:

Diagnostic Code: *(check one):* ☐ ICD-10 (preferred) ☐ DSM-5

Date of diagnosis:

Information about provider documenting diagnosis

Provider name and credentials: _____

Affiliation of provider: _____

Signature: _____ **Date:** _____

Sweetser
Promising Futures

Mental Health
Recovery
Education

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Records can be forwarded to 50 Moody Street Saco, ME 04072 or faxed to (207)284-8011

Client Name _____ DOB _____ Client ID _____

I hereby authorize the disclosure of my protected health information (PHI) as follows: Sweetser, its authorized employees and agents may:

☐ Obtain records from: ☐ Disclose records to: ☐ *Verbally* discuss my PHI with:

_____

Organization or Individual Relationship to Client Next of Kin: ☐ YES ☐ NO

_____

Street Address City State Zip

_____

Phone Fax Email

Specific information to be disclosed:

Note: Only records generated by Sweetser will be disclosed unless third party documentation is specifically identified.

☐ Progress Notes ☐ Comprehensive Assessments ☐ Psychiatric Evaluations ☐ Treatment/Service/Behavior Plans
☐ Diagnoses ☐ Crisis Intervention Assessments ☐ Medication Information ☐ Medical Info/Labs
☐ Discharge Summaries ☐ Psychological Testing Reports ☐ Other Records (be specific): _____
☐ Third Party Documentation (note organization and documents):_____

☐ **I DO** ☐ **I DO NOT**	Authorize the disclosure of information concerning diagnosis or treatment of **ALCOHOL OR DRUG USE.** *These records are protected under Federal Regulation 42 C.F.R. Part 2, which prohibits disclosure without written consent and re-disclosure, unless otherwise provided for in Regulations. I understand Sweetser cannot guarantee the recipient will not re-disclose this information to a third party.*
☐ **I DO** ☐ **I DO NOT**	Authorize the disclosure of information concerning diagnosis or treatment of **MENTAL HEALTH** conditions.
☐ **I DO** ☐ **I DO NOT**	Authorize the disclosure of information concerning diagnosis and/or treatment of **HIV INFECTION OR AIDS.**
☐ **I DO** ☐ **I DO NOT**	Want a copy of this consent.

This authorization is for the purpose(s) of:

☐ Ongoing treatment / aftercare ☐ At the request of the individual client/guardian ☐ Financial matters ☐ Education
☐ Coordination of treatment efforts ☐ Legal matters ☐ Other *(be specific):*_____

From the date of signing, this authorization is effective for 30 months **for developmental services and one year for all other services** unless an earlier expiration date is indicated. I authorize future disclosures of my Sweetser records during this time period. Earlier expiration date:_____.

I understand that:

- I have the right to review written records prior to disclosure.
- Sweetser's provision of services does not depend on my giving this consent, except that my refusing consent connected with a research project may result in my not receiving treatment as a participant in that project.
- I have the right to refuse to disclose some or all of the information in my treatment records, but that refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits / other insurance, or other adverse consequences.
- Any information disclosed outside Sweetser may potentially be re-disclosed by the recipient and no longer protected by Federal or State law.
- I have the right to revoke this authorization at any time by communicating, verbally or in writing, to any Sweetser staff, except to the extent that action has already been taken in reliance upon it. I understand revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

_____

Signature of Client **(NOTE – client must sign, regardless of age, for disclosure of Substance Use treatment records)** Date

_____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian Printed Name of Staff