Referral Form

Demographics

Today's Date:	
Caller Name/Phone/Email Relationship:	
Potential Client's Name:	
DOB and AGE:	
Gender:	
Probation Officer	Name: Email Phone number:
Parent/Guardian Information	
Social Security Number:	
Primary Insurance Provider: (Circle one)	Presbyterian or Western Sky or BCBS or NM Medicaid, or None Other: Aetna, Cigna, _____ Member ID: If other than applicant, please provide: Name of insured: _____ DOB: _____ Address: _____ Please provide copy of insurance card, front and back.
Secondary Insurance Provider: (Circle one)	Presbyterian or Western Sky or BCBS or NM Medicaid, or None Other: Aetna, Cigna, _____ Member ID: If other than applicant, please provide: Name of insured: _____ DOB: _____ Address: _____ Please provide copy of insurance card, front and back.
NO Insurance question	Do you have Medicaid? If you currently do not have Medicaid/private insurance? Are you prepared to provide proof that you have applied for Medicaid?
Current Address & County:	

Today's Date:	
Caller Name/Phone/Email Relationship:	
Circle One	Former Resident or Referral

Presenting Issues

Reason for Referral (Describe current situation)	
Current living situation (Where? with whom? Address & phone number)	

Substance Use History

List all substances used, duration of use and typical amount used. Including alcohol, prescription drugs and illicit drugs.	Substance, duration (daily/weekly, etc), amount	Estimated date of last use
Date & amount of last use of any substance. Describe any current withdrawal symptoms.	Last substance used & amount	Date used
Has he/she ever used intravenous drugs? If yes, when and how often?		

Treatment History

Name, dates and length of stay at any out of home treatment placements (detox, RTC, sober living, halfway houses). Did he/she discharge successfully?	Name and type of treatment center (RTC, detox, sober living, etc) and successful/unsuccessful discharge	Dates of Treatment Stay
Any use of medically assisted treatment (MAT)? (Suboxone, Methadone, Vivitrol) If yes, please list provider and outcome *If currently using MAT list type and dosage	Type of MAT and outcome	Dates of use or current use
List any other medications he/she has been on or is currently taking (including birth control)		

Legal Background

Juvenile Justice or Adult Criminal System involvement (please list arrests and charges/ convictions)	
☐ Assessment with criminal charges received	☐ NM Courts Record Reviewed (if applicable)
Date of most recent arrest and reason (Note if currently in detention).	
List any restraining orders, orders of protection, court dates, etc.	
The fees for our services are free for New Mexico residents. The cost for non-residents is $6,000 per month.	Spoke to _____ about fees. Employee initials: _____

No Insurance statement to be address at referral stage	In the event that you are scheduled for an Intake without proper insurance in place are you able to provide a CC on file for medication payments? If you are not, you may be prevented from certain services without having a credit card on file. Services such as MAT treatment or any other types of necessary medications.

- ***If submitting via externally, Please provide signed ROI for previous placements regarding assessments that might be needed to determine placement at Serenity Mesa.***

This information and referral form can be faxed to: (505) 877-3951

SERENITY MESA

Authorization
To Disclose Substance Abuse Treatment Information

I (Client name) ,_____,

whose Date of Birth is_____,

authorize_____to disclose to and/or obtain from: Serenity Mesa 3701 Condershire Dr SW Alb, NM 87121 505-877-3644 (Phone) 505-877-3951 (Fax) the following information:

Description of Information to be Disclosed

(Client should initial each item to be disclosed)

_____ Verification of enrollment
_____ Case Management
_____ Urine analysis results
_____ Treatment team participation and/or treatment team summary
_____ Clinical progress notes
_____ Clinical assessment
_____ Medical information including medication management, diagnosis, symptoms, summary
_____Clinical treatment plan
_____Compliance or noncompliance Serenity Mesa policy and programming
_____Other_____

_____Discharge status
_____ Discharge or transfer summary

Purpose

The purpose of this disclosure of information is for coordination of care for above mentioned client and for the safety and welfare planning of above-mentioned client. If the purpose is other than as stated above, please specify:

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Serenity Mesa at info@serenitymesa.com. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwiseindicated. A copy of this form will be maintained for a period of six (6) years from this expiration date.

Conditions

I further understand that Serenity Mesa will not condition my participation of eligibility on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

[Example: Will result in violation of probation or court ordered requirements, or ability to ensure my safety and security while I am an active participant of Serenity Mesa's housing program]

SERENITY MESA

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure ofsubstance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Staff Witness Date