SERENITY MESA

Program Referral Form

All potential clients will be Clinically assessed based on ASAM Criteria which will determine their eligibility for the Triage Center and/or our 90-day Treatment Program. Some clients will need to be admitted to the Triage Center prior to our Treatment Program or referred to appropriate community resources.

Today's Date:	**Circle One:** Former Resident or New Referral
Reason for Referral:	
DEMOGRAPHICS	
Caller Name/Phone/Email Relationship:	
Potential Client's Name and Phone Number:	
DOB and AGE:	
Social Security Number:	
Gender:	
Current living situation:	Where: With Whom: Address:
Parent/Guardian Information	Name: Email Phone number:

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. The fees for our services are free for New Mexico residents. The cost for non-residents is $6,000 per month.

Please provide a copy of the front and back of your insurance card	
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:______________________________ ______________________________________	**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: ______________________________ ____

SUBSTANCE USE HISTORY				
Substance Used	**Date of first use**	**How often?**	**How Much?**	**Date of last use**

TREATMENT HISTORY				
Please list all individual and/or group therapies (Outpatient, Intensive Outpatient), sober living, Residential Treatment Centers, Multi-Systemic Treatment (MST), Transitional Living Program, Detox Facilities, etc.				
Name of Agency	**Type of Treatment**	**Reason for Treatment**	**Date of Intake and Discharge**	**Type of Discharge**
If there is previous treatment, please provide assessments, discharge summaries, and/or other documentation supporting their participation.				

Experience with medically assisted treatment (MAT)? (Suboxone, Methadone, Vivitrol) ☐ YES ☐ NO			
Medication Name	**Provider**	**Dosage**	**Previous or current status**
If you are not currently on Medically Assisted Treatment (MAT), is there interest in learning more about this treatment? ☐ YES ☐ NO			

BIOMEDICAL HISTORY	Y	N
Has he/she had blackouts while using alcohol or drugs?		
Has he/she experiences physical symptoms when you stop using?		
Has he/she experiences emotional symptoms when you stop using?		
Has he/she ever overdosed or been hospitalized due to their drug/alcohol use?		
Has he/she ever used intravenous drugs? If yes, when and how often?		
Does he/she have any current physical health problems? (seizures?)		
If female, are you pregnant?		
Is he/she currently prescribed medications for a medical issue? If yes, please list:		
Is he/she currently prescribed any medication for mental or behavioral needs? If yes, please list:		

LEGAL HISTORY		
Is there involvement with the Juvenile Justice System or Adult Criminal System? ☐ YES ☐ NO If Yes, which one? ☐ Juvenile ☐ Adult		
Is he/she currently on probation or parole? If yes, who is the Probation or Parole Officer?		
Name:	Phone Number:	Email:

LEGAL HISTORY		
Please list current, pending, and/or previous charges:		
Date	**Offense**	**Outcome**
Is he/she aware of any current warrants for your arrest? YES NO		
Does he/she have upcoming court dates? YES NO **If yes, when?**		
Are there any current orders of protection? YES NO If yes, please explain.		

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_______Discharge status
_______ Case Management _______ Discharge or transfer summary
_______ 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____

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 one year from the date signed. A copy of this form will be maintained for 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:

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[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]

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 of substance 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.

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Signature of Patient/Client Date

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Signature of Staff Witness Date