New Hope MST - Referral Form

Referring Agency / Person:

Phone/Email:

General Info

Youth Name: **DOB:** **Age:**

Legal Guardian Name: **Relationship (Parent/Grandparent/Foster/ DSS):**

Address: **County of Residence:**

Legal Guardian Phone Number and Email:

Current Therapist (if applicable) **Name, Number, Email:**

What services is the child currently receiving:

Is the family aware of the referral to MST service? ☐ **Yes** ☐ **No** **Amenable to services?** ☐ **Yes** ☐ **No**

*****Please have guardian sign the attached release to initiate the referral and please send any applicable clinical/educ documents*

Primary Insurance Coverage

☐ **Medicaid #** _____

MCO *(please circle):*

Select health/First choice BlueChoice/Healthy Blue Molina Absolute Total Care Humana Healthy Horizon

☐ **Other/Commercial/Secondary:** _____

Current Mental Health Diagnosis (if applicable):

List of Concerns in the last 60 days (Check all that apply):

☐ **Substance Abuse**	☐ **Sexual Offending/Aggression**	☐ **Hyperactivity/Impulsivity**
☐ **Verbal/Physical Aggression**	☐ **Gang Involvement**	☐ **Anxiety / Mood Symptoms**
☐ **Defiance**	☐ **Legal Involvement**	☐ **Physical/Sexual Trauma**
☐ **Runaway**	☐ **Self-injurious Behavior**	☐ **Poor School Functioning**
☐ **Truancy**	☐ **Intellectual Disability**	☐ **Eating Disorder/Symptoms**
☐ **Sexually Reactive Behaviors**	☐ **Psychosis**	☐ **Active DJJ involvement**

Please provide a brief description of checked items (include frequency, duration, and severity of behaviors including most recent incident. Feel free to use a separate piece of paper if needed):

Has member exhibited suicidal or homicidal thoughts, gestures, or attempts within the last 30 days? ☐ **Yes** ☐ **No**

If yes, explain:

Please send referral form, signed release, and clinical documents to Admissions Team

Fax: 843.851.1075 **Phone:** 843-991-8327 **Email:** MST@newhopetreatment.com

New Hope Treatment Centers / MST
101 Sedgewood Drive
Rock Hill, SC 29732
Phone (803) 328-9300
MST Fax (843) 851-1075

Client Name: _____
Date of Birth: _____

AUTHORIZATION FOR THE RELEASE, DISCLOSURE, AND RECEIPT OF INFORMATION

I, _____, authorize **New Hope Treatment Centers** to ☐ ***disclose*** and/or ☒ ***receive*** information to/from:
(authorized rep/legal guardian)

Name: _____ Agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

E-mail address: _____

I prefer my information be sent ☐ Hardcopy by mail ☒ Facsimile (fax) ☒ Electronically

Disclose/receive for the purpose of: **Initiate referral to MST services *(in-home, community based services)***
Any disclosure of protected health information by the recipient is prohibited except when implicit in the purposes of this disclosure.

Information to be ***disclosed/received*** is identified as follows (check all that apply):

☐ Discharge Summary	☐ Recreational Assessment	☒ **Treatment Plan(s)/Reviews**
☐ Physical Examination	☐ Vocational Assessment	☐ Physician Progress Notes
☒ **Psychological Evaluation**	☒ **Psychiatric Assessment**	☒ **Interdisciplinary Progress Notes**
☒ **Psychosocial Evaluation**	☐ Physician's Orders	☒ **Alcohol & Drug Information**
☐ Nursing Assessment	☐ Laboratory Data	☒ **Educational Assessment**
☐ HIV Infection, AIDS or AIDS Related Conditions		☒ Other (please specify): **IEP, Diagnostic assessment, etc**

Federal Law 42 CFR Part 2 protects the confidentiality of drug and alcohol abuse resident records maintained by this facility. By my signature, I am authorizing disclosure of this information, if applicable.

I authorize the following additional specific information to be used/disclosed, if applicable:
☐ HIV/AIDS Information ☐ Pregnancy Tests ☐ Sexually Transmitted Disease Information

Authorization Expires: ☐ One year from signature **OR** ☐ Expiration Date or Event: _____

I understand that:

- I have the right to review the information that is being used or disclosed.
- Disclosure of information is prohibited without client's consent. Disclosed information will continue to be protected under the Health Insurance Portability and Accountability Act (HIPAA) if disclosure is to another covered entity (health provider, health plans, health care clearinghouses). The information will not continue to be protected under HIPAA, but may be subject to other privacy laws or policies if the disclosure is made to a non-covered entity. New Hope Treatment Centers is not responsible for any disclosure made by the institution authorized to receive this information.
- I have the right to refuse to sign this authorization form and, by doing so, refuse to allow the use or disclosure outlined above.
- I may revoke this authorization at any time by writing New Hope Treatment Centers**.** However, New Hope Treatment Centers may rely on this authorization until it receives written notice that I am revoking it.
- Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on obtaining this authorization.

I further authorize the information to be sent by facsimile or encrypted e-mail and I agree to hold the agency harmless if my protected health information does not reach the appropriate authorized recipient: ☐ Yes ☐ No

_____ _____
Signature of Legal Guardian Date