Region 4 South ACT Referral

Name of potential consumer: _____

Phone number: _____ County of residence: _____

Address: _____

Name of person/agency referring: _____

Phone number: _____

Current diagnosis of potential consumer:

DSM IV	DSM V
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

Functional areas of need for the potential consumer:

_____

_____

Is/does the potential consumer:	**YES**	**NO**
18 years of age or older?		
Voluntarily want ACT services?		
On a civil commitment?		
Have a legal guardian?		
Have a written SPMI statement by a mental health professional?		
Have a primary diagnosis of substance-related disorders?		
~~Have a neuro~~developmental-related disorder (example: learning disability, IQ below 80)?		
Have a neurocognitive-related disorder (example: Alzheimer's)?		
Have a Traumatic Brain Injury?		
Have a completed LOCUS?		

Indicate the most recent score: _____

Is/does the potential consumer currently or have a history of:

Hospitalizations related to mental health needs?		

Indicate where & when: _____

_____

_____

Utilizing Emergency Room Services or Crisis Services related to mental health needs?		

Indicate where & when: _____

_____

_____

***COMPLETE RELEASE OF INFORMATION & ATTACH TO REFERRAL**

	YES	NO
Utilizing residential settings due to mental health needs?		
Indicate where & when:		
Homeless?		
Indicate when:		
Incarceration (examples: prison or jail)?		
Indicate where & when:		
Utilizing other levels of mental health care (examples: Psychiatry, Individual Therapy, TCM, ARHMS, ICRS, ACT)?		
Indicate where & when:		
Substance-related treatment?		
Indicate where & when		
Have any notable medical conditions (eg: diabetes, cancer)?		
Indicate what:		
Competitive employment?		
Indicate where & when:		
Currently have medical assistance, Minnesota Care, or another public medical pay program?		
Current medical insurance provider ***including ID & group number*** :		

***COMPLETE RELEASE OF INFORMATION & ATTACH TO REFERRAL**

Please fully complete releases of information (using attached form), as applicable, for all past & current psychiatric and/or chemical dependency of the following:

- **hospitalizations (e.g. private, CBHH, ER)**
- **crisis facilities**
- **residential settings (e.g. IRTS, halfway house, adult foster care)**
- **partial hospitalization programming**
- **outpatient (e.g. therapy, psychiatric, neuropsych)**
- **community-based services (e.g. ARHMS, ICRS)**
- **legal (e.g. civil commitment, guardian, prison, probation officer)**
- **medical (e.g. primary care physician)**
- **county (e.g. case manager, financial worker)**

Please return by fax 320.335.5115, or mail to 507 N Nokomis St, Suite 203, Alexandria, MN, 56308. We will be in contact with you regarding your referral. Please call 320.335.5100 if you have questions. *Thank you!*

Region Four South Adult Mental Health Consortium
Assertive Community Team (ACT)
507 North Nokomis Street, Suite 203, Alexandria, MN 56308 320-335-5100 FAX 320-335-5115

CONSENT TO RELEASE OR EXCHANGE INFORMATION

Name of Client: _____ Birth Date: _____
(First) (Middle Initial) (Last) (Maiden)

Authorizes Region Four South ACT to: ☐ Disclose To ☐ Obtain From ☐ Disclose To and Obtain From

Name of Agency or Individual:	
Address:	
Phone:	Fax:
Contact Person:	

To release and/or exchange by electronic, paper, or verbal communication with Region Four South Assertive Community Treatment pertinent information from my case record maintained while I was/am a client. Information to be disclosed is:

☐ Diagnostic Assessment
☐ Summary of treatment contacts
☐ Progress/Medication Notes
☐ Medications
☐ Billing Records
☐ Psychological/Psychiatric Evaluation
☐ Chemical Dependency Evaluations/Notes
☐ Functional Assessment & Treatment Plan
☐ Other (Specify): _____
☐ Other (Specify): _____
☐ All medical/clinical information including HIV: Dates of Service _____
☐ All mental health information: Dates of Service _____
☐ Any and all medical records (including billing records and secondary records, mental health, chemical dependency/drug or alcohol abuse treatment records).

The purpose of the disclosure is:

☐ Case consultation
☐ Litigation
☐ Outcomes Management Survey
☐ Family involvement
☐ Ongoing care
☐ Coordination & Follow-up
☐ Notice of completion/discharge
☐ Other (Specify): _____

Revocation & Expiration of Consent:

This consent will expire upon fulfillment of its stated purpose or one year from date of signature. I understand that I may revoke this consent to release information by written notice at any time except (1) when legal action prevents revocation (probation, parole, court confinement), or (2) when requested by my insurance company, as the law provides my insurer the right to contest a claim under my policy. Any release made in good faith, prior to receipt of revocation, shall be deemed valid. A photocopy and/or facsimile of this authorization may be treated in the same manner as the original; however, Region 4 South Adult Mental Health Consortium reserves the right to require an original consent. I understand the protected health information used or disclosed per this authorization may be subject to re-disclose by the recipient and may no longer be protected.

☒ I do not need to sign this authorization to receive services unless the services are court-ordered or are being created solely for a third party (i.e. consultation).
☒ This release of information will be accepted only if all items have been completed.
☒ A fee may be assessed for the requested records.
☒ Requested information may be released directly to the person, or by mail, phone or fax.

Chemical Dependency Authorization:

Chemical Dependency records are further protected by a more stringent Federal Law (42 CFR Part 2). This information cannot be disclosed without the expressed authorization of the patient nor can the information be re-disclosed unless specifically authorized by the patient or as otherwise permitted by 42 CFR Part 2.

A photocopy/fax is equivalent to the original.

_____ _____
Date Signature of Client

_____
Signature of Responsible Party for Minor/Incompetent Party: *If you are the client's legal representative, please attach a copy of the document that gives you that authority to act as the legal representative.

_____ _____
Date Witness