

**CARROLL COUNTY HEALTH DEPARTMENT  
UNIVERSAL REFERRAL FORM**

Name: \_\_\_\_\_  
First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex:  Male  Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status  NM  M  D  Sep  Wid

Highest level of education completed: \_\_\_\_\_

Race:  American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or other Pacific Islander  White

Are you Hispanic or Latino?  Yes  No Citizenship \_\_\_\_\_ Veteran Status \_\_\_\_\_

Number of Dependents \_\_\_\_\_ Income (Annual Gross) \_\_\_\_\_

Are you Pregnant?  Yes  No Primary Language \_\_\_\_\_ Interpreter Needed  Yes  No

Unemployed  Employed  FT  PT by: \_\_\_\_\_

Emergency Contact Person –

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Are you currently in treatment?  Yes  No Where? \_\_\_\_\_

Diagnostic Impression: \_\_\_\_\_

ASAM criteria Level of Care: \_\_\_\_\_  Unknown

Source of Referral: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a regular medical doctor? Name: \_\_\_\_\_

Have you visited an Emergency Department in the past 12 months?  Yes  No

Have you had any psychiatric admissions to a hospital in the past 12 months?  Yes  No

Check any that apply: Temporary Cash Assistance  Medicare  Medicaid  None

Date Obtained: \_\_\_\_\_

# CARROLL COUNTY HEALTH DEPARTMENT UNIVERSAL REFERRAL FORM

**Please check off all services for which you are referring**

Urgent Care Referral - BPWR  Yes    Mountain Manor RSSP\*  Yes  
 PATH – Outreach and CM  Yes    Walk-in substance abuse assessment - BPWR  Yes  
 Shoemaker\* (Medical Necessity Required)  Yes  No    Ambulatory Detox - BPWR  Yes  No

**\*Referrals to Mountain Manor Recovery Support System Program (MMRSSP) and Shoemaker include:**

**(For MMRSSP please also attach referral form)**

Drug Matrix <input type="checkbox"/> Yes <input type="checkbox"/> No	Copy of Social Security Card <input type="checkbox"/> Yes <input type="checkbox"/> No
Assessment /TAP <input type="checkbox"/> Yes <input type="checkbox"/> No	Copy of Driver’s License <input type="checkbox"/> Yes <input type="checkbox"/> No
History &Physical (if done) <input type="checkbox"/> Yes (MMRSSP)	TB Assessment Form (for Shoemaker Only): <input type="checkbox"/> Yes <input type="checkbox"/> No
Readmission letter (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	PPD results (if available): _____ completed: _____
Drug Treatment Court Letter <input type="checkbox"/> Yes <input type="checkbox"/> No	
Court Order <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Recovery Services (Peer Support):** (Coaching with **Peers** who have lived experience)

Does the individual need assistance with the following?

Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No	Peer Support <input type="checkbox"/> Yes <input type="checkbox"/> No
Cash Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	Housing Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No
SSI/SSDI <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No
Unemployment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Admin. Care Coordinating Unit (ACCU – MA assistance) <input type="checkbox"/> Yes <input type="checkbox"/> No	

**CONSENT TO RELEASE INFORMATION**

I, \_\_\_\_\_, consent for \_\_\_\_\_ to send the Universal Referral Form to the Bureau of Prevention, Wellness and Recovery. I further agree that Carroll County Health Department/Bureau of Prevention, Wellness and Recovery may forward the Universal Referral Form to the agencies checked above in order to coordinate care for me. This consent will remain in effect for 1 (one) year or may be rescinded in writing at any time.

\_\_\_\_\_  
Client Date

\_\_\_\_\_  
Referral Source Signature Date

**Notes:**

**For BPWR Office Use Only**

\_\_\_\_\_  
Approved  Yes  No    Signature Date