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: _____Phone #_____
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 ☐ No

Mountain Manor RSSP*** ☐ Yes ☐ No

PATH – Outreach and CM ☐ Yes ☐ No

Walk-in substance abuse assessment - BPWR ☐ Yes ☐ No

Shoemaker*** (Medical Necessity Required) ☐ Yes ☐ No

Ambulatory Detox - BPWR ☐ Yes ☐ No

Collaboration for Homeless Enhancement (CHES) ☐ Yes ☐ No

Housing Opportunities for Individuals with HIV/AIDS (HOPWA) ☐ Yes ☐ No

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

(For MMRSSP please also attach referral form)

Drug Matrix ☐ Yes ☐ No
Assessment /TAP ☐ Yes ☐ No
History &Physical (if done) ☐ Yes (MMRSSP)
Readmission letter (if applicable) ☐ Yes ☐ No
Drug Treatment Court Letter ☐ Yes ☐ No
Court Order ☐ Yes ☐ No

Copy of Social Security Card ☐ Yes ☐ No
Copy of Driver's License ☐ Yes ☐ No
TB Assessment Form (for Shoemaker Only): ☐ Yes ☐ No
PPD results (if available): _____
completed: _____

__Recovery Services (Peer Support)__: (Coaching with **Peers** who have lived experience)
Does the individual need assistance with the following?

Food Stamps ☐ Yes ☐ No
Cash Assistance ☐ Yes ☐ No
SSI/SSDI ☐ Yes ☐ No
Unemployment ☐ Yes ☐ No

Peer Support ☐ Yes ☐ No
Housing Assistance ☐ Yes ☐ No
Medication Assistance ☐ Yes ☐ No

Admin. Care Coordinating Unit (ACCU – MA assistance) ☐ Yes ☐ 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

CARROLL COUNTY HEALTH DEPARTMENT
UNIVERSAL REFERRAL FORM

: