The BruSon Group, Inc
CLIENT REFERRAL **FORM**

___ EMERGENT
___URGENT
___ROUTINE

Consumer: _____ **D.O.B**:_____ **Age**: _____ **MR#**:_____
Sex: M F **Phone#** (H):_____ **Work**: _____ **SS#**: _____
Consumer Race (Circle One):
White Black Asian or Pacific Islander American Indian or Alaskan Native Hispanic Other
Consumer's Address: _____ **Parent/Legally Responsible Person**: _____
_____ **Address** (if different from consumer):_____
_____ _____
_____ _____

County: _____ **Phone Number** (H): _____ (W): _____
School/Grade/IEP: _____ **Family Contact/Natural Supports** (list name, relationship to consumer
_____ and contact information):_____
Phone #: _____ _____
Probation Officer:_____ **County**:_____ **Phone Number**:_____
Juvenile Court Counselor: _____ **County**: _____ **Phone Number**: _____
____ **Medicaid** ____ **Health Choice** ____ **IPRS (pending/approved)** **Year Assessed**: _____
Target Populations:_____, _____, _____ **DSM IV Axis I Diag**: _____ **GAF**: _____
Services Consumer Is Currently Receiving: _____

Service and/or Individual to Which Consumer's Being Referred: _____CSS _____OPT _____Intensive In-Home
Reason for Referral (List the primary behaviors/symptoms the consumer is exhibiting that indicate the need for this level of care.) _____

STRENGTHS /NEEDS/ ABILITIES/ PREFERENCES:
How does consumer identify his/her needs? _____
Consumer ABILITIES for treatment (e.g.; skills) and INTERESTS (e.g.; recreation, leisure, extracurricular activities):
_____

Consumer PREFERENCES for treatment/clinician (e.g.: racial/cultural/religious/gender-specific preferences):

Consumer PREFERENCES for days/times of services:_____

NEEDS:
Consumer needs including urgent needs (e.g., housing, employment, financial, budgeting, banking, child care,

Transportation) _____

Has Consumer ever been homeless? _____

FAMILY/SOCIAL HISTORY:
Who does the consumer identify as his/her family? With whom did the consumer live with growing up (e.g., parents, siblings, Grandparents, stepparents, foster family, etc.); how does consumer describe his/her relationship with family (now and in

the
past)?_____
_____
_____

Current Spouse/Significant Other (how does consumer describe relationship with that person):_____

Children/Step Children (describe involvement and relationship):
_____

History of DSS Protective Services Involvement?
_____
_____

If under 18, history of out of home placements? _____
_____

Family Dynamics-Family's potential involvement with treatment:

_____

Religious Preferences: _____ Cultural Preferences: _____
Interactions with Peers: _____
Other conflictual relationships? _____

MEDICAL HISTORY:
Family Doctor/Name and Phone Number: _____
Date of Last Physical Exam: _____ Allergies: _____
Date/Result of last TB skin test: _____ Date/Result of last HIV test: _____
Current Health Concerns: _____
Past Medical History (including significant health concerns that may have affected consumer's mental health, relevant injuries
And physical issues: _____

*In each area identify the **targeted outcomes** that are not currently, and cannot be addressed by current service Provider (s):*
*To meet Medical Necessity criteria for **Community Support Services,** the consumer must have needs in a minimum of two (2) domains:*
RESIDENTIAL_____
FINANCIAL_____
EDUCATIOBAL/VOCATIONAL_____
HEALTH_____
MENTAL HEALTH_____
SOCIAL/RECREATIONAL_____
BASIC LIFE SKILLS_____
LEGAL INVOLVEMENT _____ YES _____ NO
PERTINENT MEDICAL INFORMATION ____ DIABETES ____ HYPERTENSION ____ SEIZURE DISORDER
_____ COMMUNICABLE DISEASE
COMMINICATION BARRIERS: ___ SIGHT ___ HEARING _____ SPEECH/LANGUAGE
_____ LD (expressive/receptive/written
If Consumer is found ineligible for services, state reasons: _____
_____

Reasons have been explained to the consumer/legal guardian? _____ YES _____ NO
How was the information conveyed? _____

Verbal or written consent given to The Bruson Group,Inc. staff to contact the referral source regarding
Eligibility: _____ YES _____ NO _____ VERBAL _____ WRITTEN

Entrance Criteria
A recipient if eligible for Intensive In-Home services when **ALL** of the following criteria are met:
__There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability
__Treatment in a less intensive service (e.g. community support) was attempted or *evaluated during the assessment but was found to be inappropriate or not effective).*
__The youth and/or family have insufficient or severely limited resources or skills necessary to cope with immediate crisis.
__The youth and/or family issues are unmanageable in school based or behavioral program settings and require intensive Coordinated clinical and positive behavioral interventions.
__The youth is at risk of out of home placement or is currently in an out-of-home placement and reunification is imminent.

Name of Psychotropic medication(s):
_____
_____
Referral Source (Name/Relationship to Consumer/Agency): _____

Signature: _____ Date: _____

Acknowledgement of Consumer Choice

The BruSon Group, Inc.

Consumer: Record Number: Medicaid ID:	This form is to be completed upon referral and at annual renewal for services to document informed choice.

I, _____ (consumer, guardian) acknowledge that I have been given an opportunity to review a list of Endorsed Service Providers and the services they provide within Wake County. I understand that only medically necessary services will be authorized. I have been informed of the appropriate and available providers in the WCHS LME Provider Network that would meet my specific needs for services, location, and hours of availability.

I understand it is my choice to select an Endorsed Service Provider to address my needs and that I can alert my service provider if I would like to make a change. I can also call Consumer Rights at 212-7155 to request assistance if I experience my difficulty with changing my service provider.

Please check the appropriate box below to indicate your selection(s).

- ☐ I do not have a preference of Service Providers and understand that I will be referred to the next appropriate Service provider on the Wake County LME Intake/Referral list for _____ _____(services.

- ☐ I chose to receive _____(services) from _THE BRUSON GROUP INC. (agency/agencies) and understand that someone from the agency/agencies will be contacting me within 7 days from the date of my signature on this form to initiate the service process.

- ☐ I choose to wait for the first available appointment/vacancy for _____ (services) to be provided by _____, _____ (agency/agencies). I have received procedures for accessing crisis services and understand the risk of delaying services.

- ☐ I choose to decline _____services at this time. I have received procedures for accessing crisis services and understand the risk of declining these services.

Signature: _____ **Date:** _____

Client: _____ Date; _____

CONSENT FOR TREATMENT -MENTAL HEALTH

Consumer: _____ MR Number: _____

I, _____ hereby voluntary consent to evaluation and / or treatment by The Bruson Group Inc. I understand that this evaluation/ treatment may include the referral to a psychiatrist interview and / or monitoring of medications, referral to a psychologist for psychological testing, individual, family, or group counseling, mentoring or mental health services. I reserve the right to withdraw this consent at any time. I reserve the right to refuse, at any time, any service or treatment offered.

Notice to Consumer

It is the policy of The Bruson Group Inc., that as a consumer in our agency, you shall receive appropriate treatment and continuality of care. In order to accomplish this, information may be shared between treatment agencies for quality care. You may be asked to sign a **Consent for Release of Information** should the need arise to share confidential information. Provision of service will not be contingent upon signature of this release. Consents for release of Confidential Information shall be given voluntary by the consumers or legally responsible person. Information may be shared with appropriate agencies as necessary to protect your safety and welfare as well as that of other individuals (see release of information form).

Confidentiality of Mental Health Services Patient Records

The Confidentiality of mental health service patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose ant information identifying a patient as a person in the mental health services program **UNLESS:**

{1} The patient consents in writing;{2} The disclosure is allowed by a court order; or {3} the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulation by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal Law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program about any that to commit such a crime. Federal Law and regulations do not protect any information about suspected child abuse or neglects from being reported under Stale Law to appropriate State or Local authorities. (See 42 USC 29) dd-3 and 42 USC 290ee-3 for Federal laws and 42 CFR Part 2 for federal regulations.)

Mental Health Services Admissions
If I here for Mental Health Services, this is to verify that I have been offered referral for counseling, testing, a medical evaluation and/ or treatment and other communicable diseases.

_____ _____
Consumer Signature/ Legally Responsible Person **Date**

_____ _____
Witness Signature **Date**

Authorization to Disclose Health Information

Client Name: _____ Date of Birth _____

I, _____ hereby authorize _____
(Client or Legal Representative) (Provider Name)

To disclose specific health information from the records of the above Client to :

_____
(Recipient Name/ Address/ Phone/ Fax)

_____

For the specific purpose (s): _____

Specific information to be disclosed: Check what applies

Admission Assessment
Psychiatric Assessment
Bio-Psychosocial Assessment
Diagnostic Assessment
Aftercare Plan
Discharge Summary
Legal Guardianship Papers
Psychological Testing
Treatment Plan
Social History
History and Physical Exam
Person Centered Plan
Other information as specified _____

I understand that this authorization will expire on the following date: _____

I understand this authorization is voluntary and I may revoke this authorization at any time, provided that I do so in writing and submit The Bruson Group, Inc. , before the expiration date of this signed consent.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality regulation, the recipient may not re-disclose such information without my further written authorization unless otherwise provided by the state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS conditions, alcohol abuse, from abuse, psychological conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.

I understand that I may request a copy of this signed authorization.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Print Name Date

Authorization to Request Medical / Psychiatric Information

The BruSon Group, Inc.

Client Name: _____ Date of Birth _____

Client Medical Record#: _____ Client SS#:_____ _____

I, _____ hereby authorize _____
(client or Personal Representative) (Name of Provider/ Plan)

To disclose specific purpose (s): _____
_____
_____ Specific information to be disclosed ;
_____
_____
_____

I understand that this authorization will expire on the following date, event or condition:
_____
_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosure for financial transactions, Wherein the authorizations is valid indefinitely. I also understand that I may revoke this authorization for any time and that I will be asked to sign the Revocation Section on the back of this form . I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information ' however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS conditions, alcohol abuse, from abuse, psychological conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however , if a service is requested by a non-treatment provider(e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____
(Signature of Client) (Date) (Witness-If Required)

_____
(Signature of Personal Representative) (Date) (Signature of Personal Representative/Authority)

_____
NOTE: this authorization was revoked on (Date) (Signature of Staff)

REVOCATION SECTION

I DO HEREBY REQUEST THAT THIS AUTHORIZATION TO DISCLOSE HEALTH INFORMTION OF

_____
(Name of Client)

Signed by_____ on _____
(Enter the Name of Person Who Signed Authorization) (Enter Date of Signature)

Be rescinded, effective_____, I understand that if any action taken on this authorization prior to the rescinded date is legal and binding.

_____
(Signature of Client) (Date) (Witness-If Required)

_____
(Signature of Personal Representative) (Date) (Signature of Personal Representative/Authority)

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____ on
(Name of Client or Personal Representative/ Authority)

_____
(Date)

The client or his/ her personal representative has been informed that any action taken on this authorization prior to the rescinded date is legal and binding.

_____
(Signature of Staff) (Date) (Signature Witness) (Date)