CHILD and FAMILY
BEHAVIORAL HEALTH

External Referral

4287 Five Oaks Drive, Lansing, MI 48911
Phone: 517-882-4000/Fax: 517-882-3506

Referral Date: _____ **Referring for:** ☐ Mental Health ☐ Substance Use

Preference: ☐ In-person ☐Telehealth ☐ Phone

Client Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

Parent/Guardian: *(If Applicable)* _____ **Phone:** _____

Referring Person/Title: _____ **Referring Agency:** _____ **Phone:** _____

Insurance: _____ **Ins. ID #:** _____ **Group #:** _____

If client is female, is client pregnant? ☐ Yes ☐ No ☐ Unknown

Is client having suicidal or homicidal thoughts or engaging in self-harm behaviors? ☐ Yes ☐ No ☐ Unknown

DHHS or CPS involvement (children removed or at risk of being removed from the home)? ☐ Yes ☐ No ☐ Unknown

What substance(s) is client using? ☐ Alcohol ☐ Marijuana ☐ Prescription Drugs ☐ Other: _____

Has client had positive drugs screens? ☐ Yes ☐ No If yes, for what substance? _____

Has client injected drugs in past 30 days? ☐ Yes ☐ No ☐ Unknown

Any history of drug overdose? ☐ Yes ☐ No ☐ Unknown

Comments

Please indicate reason for referral or primary concerns:

Disclosure Authorization

I, (Client's Name) _____ hereby authorize Child and Family Charities, its director or designee, to exchange information with (CFC Division) **Behavioral Health** under the following conditions. The extent and nature of this information will concern my attendance at the evaluation or screening, pre-screening information contained within this document, whether any recommendations were made, and whether I or my family plan to follow the recommendations. The purpose of need for such disclosure is to assist the referring agency in the reaching a satisfactory disposition of my case. The authorization with remain in effect from the date signed below until the purpose for which it was given no longer exists, or unless revoked by me in writing. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; the Health Insurance Portability Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; the Mental Health Code, Section 330.1748 of Public Act 258. I understand that my health information specified above will be disclosed pursuant to this authorization, and the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Part 2, noted above, however will continue to protect the confidentiality of information that identifies me as a patient in an alcohol and/or other drug program from redisclosure. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically in one year.

_____ _____

Client Signature Date

_____ _____

Parent Signature *If Applicable* Date