Community Provider Referral Form

****This form doesn't guarantee eligibility for Rise-Up.**

It is used for supportive information only

<table>
<tr><td colspan="3">Participant's Name:</td><td colspan="2">Date:</td></tr>
<tr><td colspan="3">Referring Staff & Contact Number:</td><td colspan="2">Agency Name:</td></tr>
<tr><td colspan="2">Reason for Referral & Support Seeking:</td><td colspan="3">Special Needs:</td></tr>
<tr><td>Services in Place (check all that apply):
○ Medication Management
○ Counseling
○ SUD Treatment
○ CM/CBRS
○ Groups
○ Other: ________________</td><td colspan="3">Residence:
○ Family
○ Facility: _______________
○ Res Hab: _______________
○ Homeless</td><td>Medications:
○ Has with them
○ Home
○ Facility
Pharmacy: ___________________</td></tr>
<tr><td colspan="5">Upcoming/Next Appointments:</td></tr>
<tr><td colspan="3">Rise-Up Intake Staff:</td><td colspan="2">Eligibility Status:</td></tr>
<tr><td colspan="5">Provider Notified of Eligibility Status:</td></tr>
</table>

Authorization for Release of Health Information

Member Name_____________________________________ **Date of Birth**______________________

This authorization expires in six months **unless noted otherwise**:

☐In one year ☐On date: _______________________

The person named above is or has been a patient of:

Rise-Up
Teen & Child Crisis Center
1140 Science Center Dr.
Idaho Falls, ID 83402
Phone: 208-826-0994 Email: ybhcccdirector@gmail.com Fax: 208- 845-6801

The person named above hereby authorizes____ to
Name of Person, Provider, or Facility

☐Request health information from ☐Send health information to ☐Discuss health information with

The person named above authorizes information to be requested or release by representatives of:

Name of Person/
Provider/Facility: ____

Address: ____

Phone: ____

Fax: ____

Scope:

☐ All information regarding assessment, diagnosis, and treatment of member's condition, concern, or disease (specify): ____

☐ All information regarding care received by member the dates of:
________________________________ and ________________________________
Starting Date Ending Date

☐ Other information (specify): __Coordination & Continuity of Care______________

Authorization

____
Printed name of Member & Authorized Representative

________________________ ______________ _____________________ _____________
Signature of Parent Or Authorized Representative | Date | Signature of witness | Date

9.1.23