Standardized Treatment Referral Form
For IRT and RDDT Programs in Community Corrections

First Name

Last Name

ID Number (DOC/Case #)

(SID)

Current Offense(s)

SOA-R Assessment Date (within 6 mos/most recent)

Referral Date

Gender
Male
Female
Transgender
Intersex
Other

Custody Status
Incarcerated
In Community

Referring Agency
Name
Type: Condition of Probation
Diversion
DOC/Parole/RMOMS
DOC/Transition
Other

Supervising Officer/Agent Name
Agency
Phone

Assessors Name (If different than sup. officer)
Name
Agency
Location

Date of Birth

MRD Date

Statutory Discharge Date

Email

Victim Notification Required
No
Yes

Provider Agency/Name

Tx Target
Intensive Residential Tx (IRT)
Residential Dual Diagnosis Tx (RDDT)

Employment Status
Full-Time Employed
Part-Time Employed
Unemployed or Disabled (circle)

Supporting Information Attached

(list all that apply)

Other Assessments
(specify) ______________________________
(specify) ______________________________
(specify) ______________________________
Other Diagnostic Information
(specify) ______________________________

Required Attachments

Please submit each of the following critical documents with the referral

SSI-R – Simple Screening Instrument (Revised)
LSI – Level of Supervision Inventory
ASUS-R – Adult Substance Use Survey (Revised)
TxRW – Treatment Recommendation Worksheet
CCJMHS(A) – (If applicable)
TASC Matrix (If applicable)
Release of Information

Pre-Sentence Investigation Report (PSIR)
DOC – Diagnostic Needs Summary
DOC – Initial Needs Assessment
Parole Plan/Community Release Plan
Criminal History Information (e.g. ADS)
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Notice of Parole Board Action (If applicable)

Medical/Mental Health Info

List in any mental illness diagnoses, psychiatric or medical issues present:

Medications Currently Prescribed:

Stabilized
Not Stabilized

Previous Substance Abuse TX

Check All That Apply

Level 2 – Alcohol/Drug Education
Level 3 – Weekly Outpatient
Level 4a – Enhanced Outpatient
Level 4b – Intensive Outpatient
Level 4c – Intensive Residential
Level 4d – Therapeutic Community

Medicaid ID #

Open Access
Not Enrolled
Provider:

Cognitive Impairment Levels

None
Low
Moderate
High
Very High
Unknown

Mental Health Evaluation Needed?

Reason for MH Evaluation – Check all that apply

Mental Health Evaluation Not Needed Colorado
Mental Health Screen Triggered
ASUS Mood Score>13
LSI Items #50 and/or #47 endorsed
Other (explain)

Responsivity Issues Indicated

Check all that apply

Traumatic Brain Injury Indicated
Language Barriers
Cognitive Impairments
Trauma/PTSD
Gender Identity
Serious Medical Interference
Serious Psychiatric Interference
Literacy
Other (specify)

OBH Priority Population

Check all that apply

Pregnant – Due Date ____________________
Pregnant Intravenous Drug User
Intravenous Drug User
Women with Dependent Children

Drugs Used (if applicable):

Please Explain Details of Any Responsivity Issues Indicated Above:

Client Name		State ID#		Medicaid#		BHO#	

Substance Use Testing – Last 6 Months

Please Indicate Positive Drug or Alcohol Use History

Substance	Date

Behavioral History – Last 12 Months

Date	Violation/COPD
	Escapes/Absconds Last 12 Months:

Concerns In the Next 90 Days That Could Impact Treatment Attendance

Check All That Apply

☐ Urgent Mental Health Needs
☐ Impending Medical Appointments or Procedures
☐ DHS Issues
☐ Court or Legal Proceedings
(to include major traffic cases)

Other (Please Explain):

Risk of Self Harm

☐ None
☐ Low
☐ Moderate
☐ High
☐ Very High

Risk of Harm to Others

☐ None
☐ Low
☐ Moderate
High
☐ Very High

Risk / Caution Factors (Check All That Apply):

☐ Recent Violent Behavior/Credible Threats
☐ Recent Disruptive Behaviors
☐ HIV/AIDS/Hepatitis Risk (e.g. IV Drug Use)
☐ Sex Offender Supervision Requirements
☐ Gang/Security Threat Group Involvement
☐ Homeless/Unstable and Risky Living Conditions
☐ Medically Supervised Detox Indicated (Acute Intoxication/Withdrawal)
☐ Other (explain)

Previous Treatment Attempts & Outcome Information (Please Include Dates / Details)

Transition / Housing Destination Following Residential Treatment:

Risk of Homelessness:
☐ None
☐ Low
☐ Moderate
☐ High
☐ Very High

Client Contact Information:

Current Address OR Location of Incarceration:	Phone:
	Email:

Release of Information

My signature below hereby acknowledges consent to the release of information obtained by the above-named referring agency allowing communication between the above-named referring agency, and the above named provider-agency. This authorization is voluntary and remains in effect until there is a formal and effective termination or revocation of my release from the above-named referring agency, or unless specifically revoked by written notice. A photocopy of this release is as effective as the original. I also understand that any disclosure made is bound by Part 2 of Title 42 and recipients of this information may re-disclose it only in connection with their official duties.

Supervising Officer/Agent Signature	Date	Client Signature	Date

Advantage Treatment Centers

Alamosa	Montrose	Sterling	Fort Morgan	Lamar	La Junta	Craig
2017 Lava Lane	1230 N. Grand Ave	12220 Highway 61	219 E. Railroad Ave	800 E. Maple St.	212 Santa Fe Ave	59 W. 6th Street
Alamosa, CO 81101	Montrose, CO 81401	Sterling, CO 80751	Fort Morgan, CO 80701	Lamar, CO 81052	La Junta, CO 81050	Craig, CO 81625
719-589-7500	970-964-2777	970-522-7383	970-427-5520	719-336-0650	719-468-2126	970-824-0311

CONSENT TO RELEASE INFORMATION TO REFERRING AGENCY
42 CFR Part 2 and HIPAA

There are Colorado Laws about your right to privacy. The Agency must protect information about your health & treatment (CFR 42, Part 2, CRS 25.1, HIPAA CFR 160, 164). Information about you cannot be given to other people or agencies without your written permission, except when the law allows it. Substance abuse information & HIV/AIDS information is especially protected.

I, (Client Name), authorize

Advantage Treatment Centers, Inc. to disclose the following:

- ☐ Substance Use Assessments or Evaluations
- ☐ Mental Health Assessments or Evaluations
- ☐ Substance Use Treatment Information
- ☐ Billing Information
- ☐ Disciplinary Records
- ☐ HIV/AIDS Status
- ☐ Legal Information
- ☐ Monthly Reports
- ☐ UA/BA Results
- ☐ Level 1/Level II Status
- ☐ Progress notes related to program compliance
- ☐ Substance Use Therapy Notes
- ☐ Medication Information
- ☐ Other: ____________________

to the following members of: (Agency)
(Specific contact)

The specific purpose of the disclosure is:

____

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows: **Consent will expire two years from the date of this release, 60 days after treatment ends or if/when I revoke it in writing. Whichever comes first.**

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I do not have to sign this document to get treatment at the Agency unless treatment is required by a court or another official. My payment will not be conditioned on my permission to release private information. I understand the Agency cannot take back any information given out before I revoked permission. Copies of this form may be used in place of the original. Signatures received by fax or email will be accepted. The Agency cannot promise that people who get this information will keep it private. They may or may not have to follow the privacy laws. If the information is about substance abuse or HIV/AIDS, the people who get it are not permitted to re-release it to anyone subject to Federal laws.

Client Signature: **Date**

NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.