Harm Reduction Health

CLIENT REFERRAL FORM

- Referring organizations: please fill out Part A and ask the client to take it to the receiving organization.
- Please fill out one form per service needed.
- Receiving organization: please fill out Part B and either return it directly to the referring organization or ask the client to return it to the referring organization at the next visit. Include relevant copies of any labs or reports that would help deliver comprehensive care to the client.

PART A: Referral Slip: To be filled out by the organization making the referral (referring organization)	
Date:	
Client Name:	Date of Birth:
Referred from: **South Jersey AIDS Alliance – Oasis Center**	
HRH Nurse: **Babette Richter, RN**	Organization: SJAA
Address/phone number: **609/572-1929**	
Referred to:	Date of Birth:
Contact person: AtlantiCare Community Health	Organization:
Address/phone number: 1401 Atlantic Avenue, Atlantic City, NJ	
Hours of Operation: 8:30 – 4:30	**609/347-6442**

Services Needed/notes:

Client has tested reactive for the Hepatitis C antibody using the OraQuick HCV Rapid Test. Referral is for confirmatory testing and follow-up care including HCV PCR, HCV genotype, and HCV Fibrosure or Fibroscan, liver enzyme analysis and infection viral count with referral to infectious disease clinic for treatment consideration.

Part B: Services Provided: To be filled out by the organization fulfilling the referral

Date:	
Client ID:	**Date of Birth**:

Services Provided:

- o Services Provided: _____ _____ _____ _____
- o Services completed as requested _____ Yes _____ No
- o Follow-up needed: services: _____ _____ _____ Date for follow-up: _____

Referred to:	
Contact person:	Organization:
Address/phone number:	
Hours of Operation	

Additional Comments:

Please fax completed Part B form to South Jersey AIDS Alliance; ATTN: Babette Richter, RN at 609/572-1930

South Jersey AIDS Alliance

Authorization for Release of Information/Consent to Receive Information

I, _____ (SS# - -), do hereby consent and authorize SJAA/Oasis to **obtain/release** confidential information and to consult with the healthcare agencies and other service providers **initialed** below regarding my case management/medical care. This information includes, but is not limited to my identity, diagnosis, care plans, and treatment methods. I also understand that identifying information concerning me and my care will be provided to the State Department of Health and Senior Services, Division of HIV/AIDS Services, for statistical purposes.

Confidentiality Statement:

I understand that these agencies and their employees will keep this information confidential, and that it is being obtained in an effort to facilitate my case management/medical care. I also understand that I am not obligated to sign this form and that the services I am currently receiving will not be affected upon my refusal. There may be circumstances when information may be released without my consent such as when I am in danger of harming myself or others, suspected child/elder abuse, or court order.

_____ Network Coordinator, Atlantic & Cape May Co.

_____ ACCESS One, Inc.
__X__ AtlantiCare Regional Medical Center
Infectious Disease Associates
_____ South Jersey Legal Services
_____ Family Addiction Treatment Services
_____ Institute for Human Development
_____ Seabrook House, Inc.
__X__ South Jersey AIDS Alliance (SJAA)
__X__ SJAA/Oasis Program

_____ UMDNJ Dental Services
_____ Medicaid office
_____ Municipal Welfare
_____ Social Security Administration
_____ Mental Health Agency
_____ Atlantic Health Initiatives/Outreach
__X__ South Jersey Family Medical Centers
_____ Reliance Medical Group
_____ Other (specify) _____

My questions about this form have been answered. I understand that I have the right to revoke this authorization and can do so by signing the revocation statement below. Revocation must be in writing. Unless otherwise revoked by me, this authorization is valid for one (1) year from the date below. I understand that information that has already been released in reliance with this authorization cannot be revoked.

HIPPA Regulations Statement:

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that the information disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by HIPAA.