

County of San Bernardino
Department of Behavioral Health



INTER-PROGRAM REFERRAL

Date: _____ Triage # _____ Appointment Date: _____
(See Reverse Side)

Funding Source: _____

Client Name: _____

Phone Number: _____

Address: _____

Referring Agency: _____

Contact Person: _____ Phone Number: _____

Receiving Program: _____

Contact Person: _____ Phone Number: _____

Substance Use Status:

Client is currently substance free for _____ Days Weeks Months

Client is currently using: _____

on an intermittent regular bases

Last Day of use for any substance: _____

Client is an IV drug user

Reason Referred:

Client unable to stabilize in Outpatient Treatment; needs Residential Care
(Length of treatment from _____ to _____)

Client needs Narcotic Replacement Therapy

Client has completed Residential Treatment and needs follow-up care
(Length of treatment from _____ to _____)

Client needs detox
(Length of treatment from _____ to _____)

Client needs Dual Diagnosis Program

Other _____

To be completed by Program Receiving Referral:

Did client keep initial appointment? Yes No

Was client admitted to the program? Yes No

If no, state reason

Client not appropriate _____

Client did not wish to comply with program recommendations

Other _____

Was client referred elsewhere? Yes No

If so, where? _____ Date: _____

**County of San Bernardino
Department of Behavioral Health**



Triage Rating Criteria:

- 1. **MUST BE WITHIN 48 HOURS**
Pregnant women
IV drug users
Client who is HIV+ (self report)
- 2. **MUST BE WITHIN 7 DAYS**
Upon recommendation of DBH-ADS/agency evaluator:
 - A. Client assessed as unable to stabilize in outpatient treatment
 - B. Client released from hospital or other treatment facility
 - C. Client who has completed one type of treatment and needs follow-up
- 3. **MAY BE SEEN AFTER 7+ DAYS**
All other referrals

Release of Information

I, _____ hereby authorize the staff of:

(Street) (City) (State) (Zip)

To release information from my confidential files to:

_____ () _____
(Name of person or agency) (Phone Number)

(Street) (City) (State) (Zip)

I allow release of the following information: attendance, clinical progress, medical/psychiatric, evaluations, treatment plans, family involvement, urine test results, and other information as specified below:

Patient Signature Date Witness

Confidential Prohibition Re-disclosure

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.