**Mobile SUDS Team Consent Form**

800 Transfer Rd, Suite 31, St. Paul, MN 55114

I consent to participate in Mobile SUDS team support services offered by Minnesota Recovery Connection/M Health Fairview Partnership.

I understand that the Mobile SUDS Team is a monthly service continued at my choosing. These are peer and clinical support services to provide hope, understanding, and guidance in my substance use related goals.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Please check if phone is accurate & up to date\*

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom do you live with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ok to leave a message: YES NO

Is voicemail able to receive messages: YES NO

Is it OK to text: YES NO

Preferred method of first contact: Text Phone \*First of two contact attempts is by 10am following referral\*

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, 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 in the regulations. I also understand that I may revoke this consent at any time.

Mobile SUDS team members are mandated reporters, which means that we are required by law to report any reasonable suspicions of abuse or harm to self or others. Other information that you share with team members is held in confidence.

I understand and agree to the following:

1. I grant permission for a Mobile SUDS team member to call or text at the above phone number to support me in my recovery efforts.

2. The Mobile SUDS team is not a 245G treatment program but can provide assessments and referrals to treatment if desired.

3. Each contact with the Mobile SUDS team will be documented in a secure database. The data, minus personal identifiers, may be used in future program evaluation.

4. There is no fee for this service.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| Please note that Mobile SUDS team is unable to take responsibility for direct or delayed hospital discharges. |
| Please note that Mobile SUDS Team will either facilitate to community rule 25 or directly provide Rule 25 assessment typically within 1-2 business days. No insurance requirements. |
| If able, please fax referral documents early in hospital stay. this allows time for team to visit referral at hospital. |
| REFERRING HEALTHCARE PROVIDER EMAIL ADDRESS (TO CONFIRM REFERRAL WAS RECEIVED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referral Information |

|  |  |
| --- | --- |
| Current substances used? | Current income or employment? |
| Insurance? | Transportation situation? |
| Case manager? | Race/Ethnicity? |
| Longest period of sobriety in past? | Optional - Interest in sober support meetings (AA/NA/SMART)? Not interested - Uncertain – Low – Medium – High  |
| Psychiatry in community? (Y) (N)Therapy in community? (Y) (N) | Optional - Other supportive individuals? |

|  |  |
| --- | --- |
| Current or recent safety concerns?Suicidal (ideation or attempt) DepressionAnxiety/panic/PTSDPsychosis SymptomsSafety issues in the homeAre there any communication barriers? | Was Referral given Mobile SUDS Team Brochure? (Y) (N)Is Referral interested in SUD treatment? Residential \_\_\_\_ Outpatient\_\_\_\_\_ No\_\_\_\_\_\_\_ Maybe\_\_\_\_\_\_\_Is Referral interested in mental health therapy? Yes \_\_\_\_\_ No\_\_\_\_\_ Maybe \_\_\_\_\_ |

**County of Residence? Dakota\_\_\_\_\_ Ramsey\_\_\_\_\_ Washington** \_\_\_\_\_

**Initial contact method preferred by participant:­ ­** □ Facility visit □ Telephone Contact (by 10am next business day)

**Anticipated Discharge Date and Disposition:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Resources given to referral at hospital/detox:**

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**Optional - Any other helpful information? (For example: phone issues, supports to get involved)**

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