|  |
| --- |
| Please note that Mobile SUDS team is unable to take responsibility for direct or delayed hospital discharges. |
| Please note that only if referral is interested in full participation in program, Mobile SUDS will either facilitate to community rule 25 or directly provide Rule 25 assessment within 1-2 business days. |
| If referral does not have cell phone: Encourage them to attempt daily contact with team lead Dayne work cell: 507-382-8818. also, inform that Minnesota Recovery Connection has navigators to assist with providing phones. |
| regardless of referral, encourage patients to reach out to Minnesota Recovery Connection for additional services. |
| Please send the following documents with referral and consent form:Hospital or Detox Face SheetSW/LADC Assessment (if available at time of referral) |
| Referral Information |

|  |  |
| --- | --- |
| Current substances used: | Current employment: |
| Current Insurance: | Transportation situation: |
| Case Manager: | Race/Ethnicity: |
| Probation Officer: | Other supportive individuals (Optional): |
| Mental Health Psychiatry or Therapy in Community: | |

|  |  |
| --- | --- |
| Current or recent safety concerns:Suicidal (ideation or attempt)DepressionAnxiety/panic/PTSDPsychosis SymptomsManiaSafety issues in the home | 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 \_\_\_Are there any communication barriers: |

**Referring Provider Email Address (for confirmation of received referral fax):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Initial contact method preferred by participant:­ ­** □ Facility visit □ Telephone Contact (within 24 hours)

**Discharge disposition (PLEASE include length of stay information):**

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

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

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

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

**Mobile Substance Use Disorder Support 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 guidance, encouragement, and hope in my substance use related goals.

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

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

Ok to leave a message (circle) YES NO

Is it OK to text (circle) YES NO

Preferred method of first contact (circle): Text Phone AM PM

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 additional 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 participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_