AURORA
BEHAVIORAL HEALTH SYSTEM

Patient Referral Form

24/7 Patient Services – 480.345.5420
Fax – 480.345.5453
www.auroraarizona.com

Referral Source:	Contact Phone:	Fax #:
Is this patient currently at your office or facility? ☐ Yes ☐ No	Is the Patient voluntary? ☐ Yes ☐ No	

To assist in the assessment & referral process, please forward a copy of the patient's face sheet, the most recent progress note detailing the reason for this referral and the most recent printed medication list with dosages. If available, a copy of the most recent psychiatric evaluation &/or history & physical examination will be helpful, although, they are not required for the assessment to be done.

Received Documentation: ☐ Face Sheet ☐ Medication List ☐ Insurance Card Copy ☐ Collaborative Clinical Information

DEMOGRAPHICS

Patient Name:			
Address:			Phone #:
Gender: ☐ Male ☐ Female		Date of Birth:	Social Security #:
Insurance Company:			
Policy Number:		MH/SA Benefit Contact #:	

CLINICAL INFORMATION

Included Documentation	☐ Progress Note(s)	☐ Psychiatric Evaluation	☐ Medication Record
	☐ Verbal Report From:		
Reason for Referral/Concerns:			
Clinical Summary:			

Relevant Medical Concerns	☐ Seizure History	☐ Diabetes	☐ Fall Risk	☐ Current Infection:
	☐ Detox	☐ Communicable Disease		☐ On Methadone: mgs
Allergies:				

FOR AURORA STAFF ONLY

Disposition:	☐ Admitted	☐ Denied	☐ Provider Called At:
Reason For Denial:			

Transported By:	☐ Ambulance	☐ Taxi	☐ Self/Family Member	☐ Other:

CONTINUITY OF CARE

The following contact information should be used to assist in the coordination of care for this patient.

Provider Name:

Provider Phone Number(s):

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(Affix Patient ID label or complete information below)
Print Patient Name:
MR#:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

PLEASE CHECK ONE

☐ Aurora Behavioral Health System - West
6015 W. Peoria Ave., Glendale, AZ 85302
Tel: 623-344-4439 Fax: 623-344-4447

☐ Aurora Behavioral Health System - East
6350 S. Maple Avenue, Tempe, AZ 85283
Tel: 480-345-5400 Fax: 480-345-5451

I hereby authorize **Aurora Behavioral Health System** to:

☐ Disclose Information To ☐ Exchange Verbal Information With ☐ Request Information From

Provider or Agency Name: _____

Contact Person: _____

Address: _____

Telephone #: _____ Fax # or email: _____

I would like to have the records: ☐ ***Mailed to me*** ☐ ***I will pick-up (telephone # needed)*** ☐ ***Faxed (abstract only)*** ☐ ***Secure Email***

(1) I understand that the information to be disclosed may include information about medical, psychiatric, drug and/or alcohol, mental health, social, and/or communicable diseases such as Hepatitis, Gonorrhea, HIV, and AIDS. I request the following limitations regarding the information to be disclosed: _____ Signature: _____

(2) Please mark with an "X" or check mark the type of information to be disclosed or requested:

☐ Discharge Paperwork &/or Discharge Summary ☐ Initial Assessments ☐ History & Physical ☐ Psychiatric Evaluation
☐ Medication Reconciliation ☐ Laboratory Report ☐ Billing Statements ☐ TB record
☐ Physician Progress Notes ☐ Entire Chart ☐ Other:_____

(3) The purpose or reason for this request is for:

☐ Academic/School ☐ Armed Forces/Military ☐ Continuing Care ☐ Employment
☐ Placement/Aftercare ☐ Legal ☐ Personal Use ☐ Other:

(4) The admission and discharge periods requested are: _____ to _____

- If left incomplete, the most current discharge information will be provided.
- For an active admission, I understand that this authorization is valid for release of information covering the entire admission until discharge.

(5) Your rights regarding release of protected health information (PHI):

- Your records are protected under the Federal regulations governing Confidentiality of Alcohol & Drug Abuse records (42 CFR. Part 2) which prohibit further disclosure without written consent unless provided for by law or regulation.
- I understand that I may refuse to sign this authorization. My signature is voluntary and treatment or eligibility for benefits is not conditioned upon the execution of this authorization. If not subject to federal, state, or HIPAA confidentiality regulations, I am aware that the recipient may re-disclose my PHI without my permission.
- I understand the matters discussed on this form and that I can receive a copy of it. I release the provider and its employees of liability for the disclosure of my information pursuant to this request.
- ***Fees***: Patient - $1.00 per page, no retrieval fee. If mailed, postage fees apply. Storage fee applies for older records.

This authorization shall remain in effect for sixty (60) days from the signature date unless further limitation is set here by the patient or legal representative _____. You can revoke this authorization at any time, except to the extent that action has been taken, by providing a date of revocation and signing below or by writing to the Privacy Officer of the institution where the authorization originated. Full Revocation: I revoke this authorization as of: _____Signature:_____

Patient Signature:	Birthdate:	Date:	Time:
Responsible Party Signature:		Date:	Time:
Relationship:		Telephone:	
Witness Signature:	Title:	Date:	Time:
Physician Approval Signature: *(For patient/ representative requests only)*		Date:	Time:

*Staff Notes/Date Processed:*_____