



QCI Behavioral Health

Referral for Services:

Please fill in all questions to expedite referral process.

Note: QCI serves individuals with Medicaid and uninsured.

Please indicate which County you are requesting services in:

Washington County Prince George's County Charles County Calvert County St. Mary's County

Please indicate service(s) for which you are referring this individual:

Mobile Treatment Services Outpatient Mental Health Services
 Rock-Ward Center Homeless Program

Does the patient speak English? Yes No NOTE: QCI only provides services for English speaking patients at this time. QCI will attempt to point non-English speaking individuals to appropriate resources to the best of our ability.

Patient Name _____ **Referral Date** _____
Address _____ **Apt** _____
City _____ **State** _____ **Zip Code** _____
Phone _____ **DOB** _____
SSN _____ **Gender:** Female Male

Race American Indian/Alaskan Native Asian Black/African American
 Native Hawaiian/Other Pacific Islander White

Ethnicity Hispanic or Latino Not Hispanic or Latino **Marital Status** Single Married Divorced
Smoking Yes No If yes, how many packs/day? _____

Is the Patient a Veteran? Yes No Unknown If yes, where? _____

Emergency Contact _____
Relationship to patient: _____ Phone: _____

Legal guardian name (if applicable) _____
Relationship to patient: _____ Phone: _____

Rep payee (if applicable) _____
Relationship to patient: _____ Phone: _____

Probation/Parole Officer (if applicable): _____ Phone: _____

Employed? Yes No If yes, where? _____
If no, are you actively seeking employment? yes no

Does the Patient have any type of medical insurance?
Insurance Carrier: _____ ID #: _____

If Patient has no insurance, one of the following Grey Zone eligibility criteria must be checked:

- Homeless SSDI for mental health reasons Received services in the public mental health system within the 2 years
- Discharged from a Maryland psychiatric hospital or residential crisis bed within the past 3 months
- Referred by order of a Conditional Release Released from Dept. of Corrections/prison/jail within the past 3 months

Where is the Patient living? _____

Briefly describe the Patient's needs? _____

History of psychiatric hospitalizations: Yes No If yes, please indicate facilities and dates of service:

Please attach discharge summary if available.

History of court charges and incarcerations (check where applicable):

- Drug-Related Theft Assault Weapons Possession Sexual Other

Number of arrests in the past 90 days: _____

Current Medications(s), dosage, directions/how often, prescribed by: _____

Has Patient ever been diagnosed with Autism, Asperger's, Pervasive Developmental Disorder (PPD) or any other developmental disability? Yes No If yes, what was the diagnosis? _____

Is Patient under a doctor's care for the above mentioned? Yes No If yes, where _____

Is the Patient a hurricane victim? Yes No If yes, which storm _____

Mental Health Diagnosis (if known): _____

Recent Assessment Measures (optional): _____

Social/Environmental/Physical Health Issues: _____

Additional Contacts:

Physician: _____ Phone: _____

Case Manager: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Therapist: _____ Phone: _____

Referral source:

Is this a self-referral? Yes No If no, please complete the following information and attach a signed release so that we may contact you for follow-up if needed.

If patient is being discharged from the hospital, please send patient's records upon release.

Contact: _____ Phone: _____

Hospital: _____

If patient is being referred by another organization:

Contact: _____ Phone: _____

Organization: _____ Relation to Patient: _____

Patient Agreement:

I wish to be considered for services with QCI Behavioral Health.

Patient Signature: _____ Date: _____

Transportation

___ Patient needs transportation If yes, are special accommodations needed? ___yes ___no

___ Patient does not need transportation

Client applied for (check all that apply): ___Medical Assistance ___SSI/SSDI

- **Please include copy of most recent:**
 - Discharge summary
 - Physical exam
 - Results of any diagnostic testing including EKG and labs
 - List of current medications including any long-acting injections given

- **Patients should bring to their first visit:**
 - ID
 - Social Security card
 - Birth certificate
 - Proof of income
 - Health insurance card
 - If ID does not have a Maryland address, please bring proof of Maryland residency:
 - Utility bill or Lease
 - If the patient is a minor, please bring immunization records.

QCI STAFF

Processed by (name) _____

Date received _____



QCI Behavioral Health

Authorization to Disclose Health Information/Release of Information

Patient Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ DOB: _____

I authorize the use or disclosure of the above named individual's health information as described below:

A. The following individual or organization is authorized to:

_____ release the information _____ receive and use the information

Individual/Organization Name: _____

Address: _____

Phone: _____ Fax: _____

B. The following individual or organization is authorized to:

_____ release the information _____ receive and use the information

Individual Name/Organization Name: QCI Behavioral Health, LLC

9475 Lottsford Road, Suite 250
Largo, MD 20774
Ph: 301-636-6504
Fax: 301-636-6509

5010 Regency Place, Suite 203
White Plains, MD 20695
Ph: 240-427-3554
Fax: 240-419-2556

201 North Burhans Boulevard
Hagerstown, MD 21740
Ph: 301-791-0032
Fax: 301-797-4760

C. The purpose(s) for which the information may be released:

_____ At the request of the patient _____ Continuation of care/consultation

_____ Social Security/Disability Certification

_____ To pass on message to the patient; determine the patient's location

_____ To exchange information concerning the patient illness and treatment

_____ Other: _____

D. If not previously revoked, this authorization will terminate on the earliest of the following dates:
One year from the signatures date below, or upon the following date, event, or condition:

(For authorizations to terminate due to an event or condition, the parties authorized to release information above must be notified in writing upon occurrence of the event or condition to cancel authorization.)

What information is being released:

Items below may include information on substance abuse and HIV/AIDS status unless indicated otherwise here:

____ Do not disclose substance abuse information ____ Do not disclose HIV information

____ Emergency Room Record ____ Entire record except psychotherapy notes

____ Most Recent History and Physical ____ Referral ____ Immunization Record

____ Intake Interview ____ Medication List ____ Psychiatric Evaluation/Diagnosis

____ Discharge Summary ____ Psychological/Educational Report ____ History of Allergies

____ Psychosocial Assessment ____ Pathology Report ____ Verbal Communication

____ Diagnostic Test/Results (labs, x-rays, and other test results) ____ Most Recent Physical Exam

____ Other: _____

____ Psychotherapy Notes (Due to the highly sensitive nature of psychotherapy notes federal law requires a separate authorization form for their disclosure.)

E. **Dates of information** (it applicable): From: _____ to _____

F. **In understand the following:**

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. **Revocation:** I have the right to revoke this authorization at any time. If I choose to cancel the release of information/authorization, I must notify the person/company identified in Section B in writing that I revoke this authorization. The revocation will not apply to information that has already been released in response to this authorization. **Re-disclosure:** If this information is to be received by individuals or organizations that are not health care providers, health care clearing houses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed and no longer protected by federal privacy regulations. Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws. **Conditioning of eligibility:** QCI Behavioral Health will not withhold treatment from me if I refuse to sign this form.

G. **Signature:** _____ **Date:** _____
Patient, Parent, Legal Guardian

Authorizations signed by a legal representative must include a copy of the Guardianship papers or a Power of Attorney.

Witness (if client is unable to sign):

Signature: _____ Date: _____