gateway FOUNDATION

Addiction Medicine.
Saving Lives.

Referral Form
Patient Treatment

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Is it okay to leave a message at this number? ☐ Yes ☐ No

Parent or legal guardian name, if under 18 _____

Payer Source ☐ Insurance ☐ Private Pay ☐ Unfunded ☐ Medicaid ☐ Other

REFERRAL SOURCE INFORMATION

Referral Name _____ Organization _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____

PREFERRED TREATMENT CENTER

Illinois

- ☐ Aurora
- ☐ Carbondale
- ☐ Caseyville
- ☐ Chicago Independence
- ☐ Chicago Kedzie
- ☐ Chicago River North
- ☐ Gurnee
- ☐ Jacksonville
- ☐ Joliet
- ☐ Lake Villa
- ☐ Pekin
- ☐ Springfield
- ☐ Springfield Outpatient
- ☐ Swansea

Delaware

- ☐ Smyrna

California

- ☐ Beacon House
- ☐ Beacon House Outpatient

RELEASE OF CONFIDENTIAL INFORMATION

The Gateway Foundation Authorization for Release of Confidential Information must accompany this Patient Treatment Referral Form in order for a referring individual or organization to obtain patient status of their referral.

FAX COMPLETED FORM TO: 888.975.0939

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Authorization for Release of Confidential Information

I, _____ , _____ ,
Name of Client — Date of Birth

authorize GATEWAY FOUNDATION to disclose to and/or obtain from:

_____
Name of hospital, practice, provider or person; title of person or organization

The following information from my drug/alcohol and/or mental health treatment record:
(Client should initial each item to be disclosed)

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Medications
- ☐ Presence/Participation in Treatment
- ☐ Lab Reports/Drug Screens
- ☐ Educational Information
- ☐ Discharge/Transfer Summary
- ☐ Continuity of Care Documents
- ☐ Progress in Treatment
- ☐ Medical Records from other Treating Providers
- ☐ Nutrition Screen
- ☐ Other _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, when appropriate, coordinate care services or for other purpose, please specify:

_____

My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I also understand that I have the right to revoke this authorization in writing at any time, by sending written notification to my treating Gateway facility. I further understand that a revocation is not effective to the extent that the disclosure agreed to has been acted on. If not previously revoked, this authorization expires one year from the date of my discharge, unless otherwise indicated:

_____

_____ _____
Client Signature — Date

_____ _____
Parent or legal guardian, if under 18 — Date

_____ _____
Personal Representative — Authority to Represent

_____ _____
Witness — Date

4/17/2017