Open Heart Leaders Referral Form

Date of Referral: _____ ☐ Mediation ☐ Mentorship ☐ Life Coaching ☐ Group

Referring Party Name/Phone number: _____

Client Name: _____ Gender: ____ Age: ____ DOB: _____

Parent/ Caregiver Name: _____ Relationship: _____

Address: _____

Phone: _____ Alternate Phone (work, msg., cell, email, etc.):_____

Name of Probation officer/ CWS worker (*optional*): _____

Contact number: _____

Days/Times client is available for sessions: (Be specific)

_____

When will client be available to start: ☐ Immediately ☐ Other _____

Is this court mandated? ☐ **Yes** ☐ **No** Specific Requirements: _____

Current Diagnosis Information *(optional)*: Diagnosis: _____

What is the reason for the referral? What are **the issues and behaviors for client?** (Specify if family or couple)

_____

_____

_____

_____

_____

_____

_____

Please identify all risk factors, or special concerns/issues (DV –including hx, violence, runaway, safety, SI):

_____

_____

_____

Approved Number of Sessions: _____

Recommended Frequency: ☐**Weekly** ☐ Bi-Weekly ☐ Monthly

Authorization Start Date: _____

1913 Euclid Avenue, San Diego, California, 92105
(858) 256-OPEN(6736)~ office
info@openheartleaders.org
www.openheartleaders.org

AUTHORIZATION TO DISCLOSE PRIVATE INFORMATION

_____ _____ _____
(Print full name) (Birth date) (Social Security No.)

AKA:_____ Phone Number:_____

I authorize the use or disclosure of the information identified on this form of the individual named above.

Between: Open Heart Leaders and: _____
1913 Euclid Avenue, San Diego, CA 92105 _____
(858) 256-6736~ office _____

I understand that authorizing the disclosure of this private information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an authorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my private information I can contact: Open Heart Leaders

The disclosure of information and records authorized herein is required for the following purpose:
Care Coordination

I specifically request that the following information be released:

€ Diagnosis
€ Intake/Discharge Summary
€ Mental Health Evaluation
€ History & Physical Exam
€ School Records (IEP, Attendance, Disciplinary)
€ Treatment Plan/Service Plan
€ Psychological Evaluation (testing)
€ Physician Orders
€ Medication Administration Records
€ Psychiatric Assessment
€ Laboratory Reports
€ Legal Information
€ Other: Verbal Communication

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to: Open Heart Leaders. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my referral source when the law provides my referral source. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ and/or upon Discharge/Completion of services with OHL Provider(s), whichever comes first.

If no expiration date, event or condition is specified, this authorization will expire in six months after discharge.
I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

_____ _____
(Signature of Client) (Date)

_____ _____
(Signature of Parent, Guardian, Client Representative) (Date)