CENTRAL CITY CONCERN
HOMES HEALTH JOBS

Hooper Detoxification Stabilization Center
1535 N. Williams Avenue
Portland, OR 97227
Main 503.238.2067
Email hooperreferrals@ccconcern.org

Hooper Appointment Referral Packet

Appointments are available Monday through Friday with four total slots available at **9:00 AM, 10:00 AM, 11:00 AM, and 12:00PM.** We ask that patients **arrive 20 minutes early**. We require a ten day supply of medications in the original package (including insulin and inhalers). Controlled substances such as Suboxone, Librium, Ativan, Adderall, barbiturates, and Lyrica are not allowed in our facility. Please do not bring controlled substances unless the intent is to destroy them. Please call or email if you're unsure what to bring. You may bring T-shirts, undergarments, books, journals and quarters for the phone.

Referring providers, please fill out the attached items and email the completed forms to: HooperReferrals@ccconcern.org

Referrals will be accepted between the hours of 9:00 AM and 3:00 PM

A staff member will call you to schedule an appointment.

Contact Information

We will call you and the client back to schedule the appointment within 30 minutes of receiving the referral.

What is the best number to use to reach you both? _____

Please Note

You must speak with the Hooper admissions team to confirm appointment availabilty. If they do not schedule you into a slot, you do not have an appointment.

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Hooper Appointment Referral

General Information

Today's Date: _____ **Date of Birth:** _____

Legal Name: _____ **Preferred Name:** _____

What is your legal sex? ☐ Female ☐ Male **Are you pregnant?** ☐ Yes ☐ No

What is your gender? ☐ Female ☐ Male ☐ Trans Female/Trans Woman/Affirmed Woman
☐ Trans Male/Trans Man/Affirmed Man ☐ Genderqueer/Gender Non-Conforming
☐ Agender/Without Gender ☐ Declined ☐ Additional Category:_____

Which pronouns do you go by? ☐ She/Her ☐ He/Him ☐ They/Them ☐ Don't Know
☐ Decline to Answer

Medical Information & History

From which substances do you require detox?

_____

_____

Do you use the above daily? ☐ **Yes** ☐ **No**

Have you used this substance in the last 48 hours? ☐ **Yes** ☐ **No**

How long have you been using this substance without a break? _____

Do you have withdrawal seizures or DTs? ☐ **Yes** ☐ **No** **Date of Last Seizure**_____

What substance have you used in the past month?

☐ Other opiates like, Vicodin, Morphine, and Methadone
☐ Benzodiazepines, like Ativan, Klonopin, Xanax or Valium
☐ Additional substances: _____

Do you have a primary care provider?

☐ Yes If yes, please give the provider's name & clinic name: _____
☐ No If no, would you like to have a primary care provider at Old Town Clinic? ☐ Yes ☐ No
☐ I'm waiting for my first provider visit at Old Town Clinic.

- When was the last time you saw a medical provider? _____
- What did you see this provider for? _____

When was the last time you were a patient in the Emergency Room? _____ ☐ Never

If you've been to an Emergency Room, which one did you last go to?

☐ Good Samaritan ☐ Emanuel ☐ Providence Glisan ☐ St. Vincent's ☐ VA ☐ Kaiser
☐ OHSU ☐ Mt Hood ☐ Adventist ☐ Providence Milwaukie ☐ Other: _____

What was the main reason for your visit to the Emergency Room? _____

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Medical Conditions

Please check all of the conditions you have now or have had in the past:

Skin
- ☐ Rash
- ☐ Itching
- ☐ Abscesses (location_____)

History of:
- ☐ Endocarditis
- ☐ Sepsis
- ☐ Blood clot (DVT)

Liver Conditions
- ☐ Hepatitis (type ____)
- ☐ Other: _____

Kidney Condition
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Other: _____

Heart Conditions
- ☐ High Blood Pressure (Hypertension)
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ Heart Failure or Congestive Heart Failure (CHF)
- ☐ Atrial Fibrillation
- ☐ Other Abnormal Heart Rhythm
- ☐ Other: _____

Neurologic (Brain) Conditions
- ☐ Seizures
- ☐ Stroke
- ☐ Memory Problems
- ☐ TBI (Traumatic Brain Injury)
- ☐ Other: _____

Diabetes and other Endocrine or Gland Conditions
- ☐ Diabetes
- ☐ Thyroid Condition
- ☐ Other: _____

Lung Conditions
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Pneumonia (when? _____)
- ☐ Other: _____

Infections
- ☐ Tuberculosis (Did you complete treatment? Y N)
- ☐ HIV
- ☐ Sexually Transmitted Infection (type: _____)
- ☐ Frequent Skin Infections
- ☐ Other: _____

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Thoughts of Suicide
- ☐ Other: _____

Other
- ☐ Hearing Problem (Type: _____)
- ☐ Eye Problem (Type: _____)
- ☐ Cancer (Type: _____)

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Please describe any other medical problems or serious injuries you have had:

_____

_____

_____

Surgeries

Which surgeries have you had?

Type of Surgery	Approximate date/year

☐ I've had additional surgeries that I don't have space to list here.

Medications, Allergies, Pharmacy

Please check anything that you're allergic to (medications, foods, etc.):

☐ Penicillin ☐ Tape ☐ Other: _____
☐ Sulfa ☐ Latex

Name of pharmacy that you usually use: _____

Address and phone number of your pharmacy (if known): _____

_____

Please list all medications, vitamins, and supplements (herbal or natural) that you are taking

Name of Medication, Vitamin, or Supplement	Dose (if known)	Times per day?

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Name of Medication, Vitamin, or Supplement	Dose (if known)	Times per day?

☐ I take additional meds, supplements or vitamins that I don't have space to list here.

Sexual & Relationship Health (optional)

I think I may be at risk for HIV/AIDS: Yes No Not Sure

I would like to be tested for sexually transmitted infections Yes No

I'm currently in an intimate partnership. Yes No

- If yes, do you feel emotionally and physically safe with your partner? Always Sometimes Never

Other

Anything else we should know?

_____

_____

Thank you!

To be completed by Hooper staff only

Reviewed by: _____ **Date:** _____

Insurance Verified_____ **Date:** _____

Alerts _____ **Date:** _____

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REFERRING PROVIDER/AGENCY INFORMATION	
Instructions: ❖ ***Please complete this page with your contact information.*** ❖ ***In order for us to confirm patient admission status, please complete the ROI beginning on the next page including type of information to be shared.***	
Name of referring Agency:	
Name of contact person making referral:	**Phone #:**
DISCHARGE:	
Name of Agency patient is to be discharged to:	
Name of contact person for discharge planning:	**Phone #:**
Notes for processing:	

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Client name: _____
Client number: _____
Client birthdate: _____
Telephone no: _____
Client/Patient Identification

AUTHORIZATION TO USE AND RELEASE PROTECTED HEALTH INFORMATION

*ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.*

I authorize the following CCC entity: Hooper Detoxification Stabilization Center
(name of CCC entity/facility)
1535 N. Williams Ave., Portland, OR 97227
(address of CCC entity/facility)
503-238-2067 (telephone of CCC entity/facility) 503-238-2004 (fax of CCC entity/facility)

to receive and disclose a copy of the specific health information described below regarding:

_____
(name of client/patient)

consisting of:
- ☐ All health information
- ☐ Discharge summary
- ☐ UA results
- ☐ Progress notes
- ☐ Other, specify: _____
- ☐ Medication orders
- ☐ Assessment
- ☐ Labs
- ☐ Presence in treatment
- ☐ Treatment plan/progress
- ☐ Medication administration

to and from:
_____
(name of entity/facility)
_____
(address of entity/facility)
_____ (telephone of entity/facility) _____ (fax of entity/facility)
_____
(relationship to client/patient)

for the following:
- ☐ Emergency contact
- ☐ Disability
- ☐ Other, specify: _____
- ☒ Continued care
- ☐ School entry
- ☐ Family/friend
- ☐ Legal

by means of:
- ☒ All forms of communication (verbal, written, electronic, and other)
- ☐ Verbal only
- ☐ Other, specify: _____

My initials below authorize the inclusion of the following information as part of this authorized release of records:

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information

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_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that I have the right to revoke this authorization, at any time, provided that I do so in writing, and provided it is directed to the entity responsible for completing the release of information detailed in this document. If I choose to revoke this authorization, it will no longer be used for the reasons covered by this authorization. I understand that disclosures made prior to revoking this authorization cannot be rescinded. I understand that I do not have to sign this authorization. I understand that if I choose not to sign this authorization, my health care and payment for that health care cannot be conditioned upon receipt of this authorization and will not be affected.

This authorization becomes effective on the date below, and **will expire one year (12 months) from my last date of treatment at Central City Concern**; a period reasonably needed to complete the disclosure of information for the purposes described and named within this authorization and named within this release **unless I indicate otherwise.**

☐ Specific expiration date: _____

I have reviewed and understand this authorization. I also understand that the health or health-related information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, if permissible by law, and will no longer be protected under the appropriate federal and/or state regulations pertaining to the information released herein. If the information released contains alcohol and chemical dependency diagnosis and/or treatment records, the records are further protected by federal confidentiality rules (42 CFR, Part 2). The federal rules prohibit further disclosure of this information unless I expressly permit the disclosure by written authorization or as otherwise permitted by 42 CFR, Part 2. A general release of medical or other information is NOT sufficient. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

By: _____ (client/patient signature) _____ (date)

By: _____ (client/patient representative signature) _____ (date)

Witnessed by: _____ (witness signature) _____ (date)

OPTIONAL: For administrative use only

☐ **Records request submitted:** _____ (date)

☐ **Records sent:** _____ (date)

☐ **For file only**

REVOCATION OF AUTHORIZATION

By signing below, I hereby revoke this Authorization to Use and Release Protected Health Information.

Client/Patient Signature Revoking Consent: _____

Printed Name: _____

Date Consent Revoked: _____