LRADAC TREATMENT AND INTERVENTION SERVICES REFERRAL FORM

☐Lexington
1068 South Lake Drive
Lexington, SC 29072
Phone: 803-726-9400
Fax: 803-726-9650

☐ Richland
2711Colonial Drive
Columbia, SC 29203
Phone: 803-726-9300
Fax: 803-726-9650

Program Referring to:

☐ Adult Outpatient
☐ Adolescent Outpatient
☐ ADSAP
☐ Detox
☐ Family Services
☐ AEP / PTI

Recovery from alcohol and drug problems is a process of change through which an individual achieves improved health, wellness and quality of life. We recognize that addiction affects individuals in many areas of their lives. LRADAC actively embraces and supports a systems approach to recovery. Our Recovery Oriented System of Care supports person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, family and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems.

PATIENT INFORMATION:

Today's Date: _____

Patient Name		Date of Birth	
Home Phone Number		Mobile Phone Number	
Street Address	City	State	Zip Code

REFERRAL INFORMATION:

Referring Agency	Department	Staff Email	
Staff Name, Print	Phone Number		Fax Number
Street Address	City	State	Zip Code
Reason for referral:			

Is participation and successful completion mandatory? Yes ☐ No ■

Is the patient currently pregnant? Yes ☐ No ☐

Referring agency confirms responsibility for payment of services: Yes ☐ No ☐

Authorized Signature (if yes): _____

By signing below, I consent to allow LRADAC to contact the above mentioned agency/staff by phone or in writing, to disclose if/ when I complete my assessment. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires ninety (90) days from the date of signature.

I understand that, generally, this agency may not condition my treatment on whether I sign a consent form, but that, in certain limited circumstances, I may be denied treatment if I do not sign a consent form.

Print Name: _____ **Patient Signature:** _____