



# Hawaii Access To Recovery Referral Form

Name (full): \_\_\_\_\_ Alias(es): \_\_\_\_\_ DOB: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ @ \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone - Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Legal Guardian (if applicable): \_\_\_\_\_ Address (if different): \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact\*: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*May we have your written permission to contact this person if we need to locate you to see how you are doing? YES NO**

CWS/VCM/FSS Case Worker: \_\_\_\_\_ Phone: \_\_\_\_\_

Section /Unit/Area: \_\_\_\_\_ Release of Information to ATR signed by client? YES NO

Prior Substance Abuse Treatment: YES NO Previous Substance Assessment (please circle): YES NO

Month / Year: \_\_\_\_/\_\_\_\_ Agency: \_\_\_\_\_

The following Recovery Support Services (RSS) may be helpful to this client: (Circle all that apply)

Child Care                      Transportation                      Housing Support                      Spiritual Support  
Cultural Support                      Sober Support Activities                      Gap Funds for (be specific): \_\_\_\_\_

I understand that coordination of my Recovery Support Services may require that my basic identifying information may be available to other ATR Recovery Support Services Units. This is to avoid duplication of services or record entries. In signing this document, I agree that ATR RSS Units will have access to my basic identifying information. I will not be transferred or referred for primary RSS Unit services without my consent in writing authorizing such a transfer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

RSS Intake Unit: \_\_\_\_\_ Date: \_\_\_\_\_

Confidentiality is very important for treatment and recovery. If I see or hear about other ATR participants in the course of my contact with ATR, I agree to keep the names of those people and other information about their treatment and recovery private and confidential. \_\_\_\_\_ (Please Initial)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

### CAGEAID\*

1. Have you ever felt you should cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you ever felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or drug first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

Positive Score is yes answer on any one or more of above questions. Score: \_\_\_\_

\*Brown, R.L. (1992). Identification and office management of alcohol and drug disorders. Addictive Disorders, Mosby Yearbook.