



1820 Center Avenue, Suite 170 · Janesville, Wisconsin 53546
Phone: (608) 755-1475 · Fax: (608) 755-1733

PROJECT TREAT
(Transitional Recovery Services to Empower, Assist, and Transcend)

REFERRAL FOR SERVICES

Referral Date: _____ Anticipated Release Date: _____

Date of Incarceration: _____ Huber: **YES** **NO** Starting date: _____

Participant Full Legal Name: _____

Participant's Current Location: _____

Contact Number upon Release: _____ DOB: _____

Reason for Referral: _____

Current Offense(s): _____

Sentence: _____

Supervision to follow? Yes No

Housing plan when released: _____

If yes, Agent Name and Phone Number: _____

Drug(s) of Choice: _____

History of IV needle use? Yes No

Does the Participant have any chronic or acute medical conditions? Yes No

If yes, please list: _____

Any need for language/interpretation services? If yes, please explain: _____

Is participant currently pregnant: Yes No

Does participant have any mental health issues, if yes please explain. Yes No

Has the participant tested positive for any of the following?

TB: Yes No

Hepatitis B: Yes No

HIV: Yes No

Hepatitis C: Yes No

Narrative

Please provide any additional information that may be helpful to the Project TREAT team:

If a DOC referral please attach COMPASS.

Contact Information for Person Completing Referral:

Name: _____

Location: _____

Email: _____

Phone: _____

*****Please include a signed Release of Information. *****

**For questions or additional information, please call Camryn Withrow at
(608)755-1475.**



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File Request Send

AUTHORIZATION TO RELEASE RECORDS

Patient Name: _____ DOB: _____ Phone Number: _____

I request and authorize CBHC to **release to** **receive from**, health care information of the patient named above to:

Wisconsin Department of Corrections
(Including Probation and Parole Offices)
3099 E. Washington Ave.
Madison, WI 53704

Rock County Jail
(Including RECAP Program)
200 US-14
Janesville, WI 53545

- Mental Health
- AODA
- HIV Status

(Organization/Individual)

(Street Address)

(City, State, Zip)

****Under this grant CBHC and project TREAT cannot drug test for the purposes of judicial/correctional supervision with the sole intent of the administration of justice such as punishment or sanctions without therapeutic intervention.**

This request and authorization applies to:

- MH Assessment AODA Assessment Treatment Plan/Review Psychological Evaluation Psychiatric Evaluation
- Psychiatric Psychotherapy AODA Notes Lab Data Appt. Confirmation/Billing Medication List/Physicians Orders
- Discharge Summary Progress Information Two-Way Exchange of Information (**Verbal**)

Dates of Service: All records: last 2 years up to two weeks post discharge from project TREAT or completion of supervised release whichever comes first

Purpose for Disclosure: (check all that apply)

- Further medical care Patients Request Insurance/Benefits Disability Determination Litigation
- Emergency contact: health/location disposition Reporting Progress/Participation

I understand that I have the right to a copy of this form and inspect the information which is to be released. I further understand that the records contain information regarding the patient's medical condition and treatment and possibly could include information pertaining to drug and/or alcohol usage and/or mental health status and/or AIDS or HIV related illness. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and may not be protected by federal confidentiality rules. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization without my services being terminated. I may experience consequences for not signing this authorization if referred from a mandated agency.

Signature of Patient (includes minors 14 years of age and over)

Date Signed

Signature of Parent/Guardian/Personal Representative (Relationship)

Date Signed

Signature of Witness

Date Signed