COMPASS Behavioral Health Clinic
TRANSFORMING LIVES

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 Gregory Shepard at (608)755-1475.

10/2022
Project TREAT referral form

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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