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KY-Moms
Maternal Assistance Towards Recovery

Kentucky Moms MATR - Patient Referral Form

Referral Guidelines

1. To refer a potential pregnant patient or a patient no more than 60 days post-partum, please complete this form and return it, along with a copy of the release of information form to prevention@newvista.org.
2. The patient you refer will be contacted by a Kentucky Moms MATR Prevention Specialist or Case Manager within 48-hours of receipt of this Referral form.
3. Only one referral per pregnancy, per patient can be made. If a patient is referred by more than one medical provider, the first referral received will be the one accepted.
4. Please complete a signed patient Release of Information form on following page.

Patient Information

Patient Name: _____ Date of Referral: _____

Patient Address: _____

Preferred Method of Contact (Please check at least one): ☐ EMAIL ☐ PHONE ☐ TEXT

Email Address _____

Cell Phone: _____ Home Phone: _____

Please check patient's current status: ☐ Pregnant ☐ Post-Partum Diagnosis Code: _____

Due Date/Delivery Date: _____ Medicaid #: _____

Does patient currently present with substance use RISK FACTORS during pregnancy? ☐ YES ☐ NO

Does patient currently present with substance use CONCERNS during pregnancy? ☐ YES ☐ NO

Referring Agency: _____

Referring Doctor: _____ Signature: _____

For Kentucky Moms MATR Use Only

Date Received: _____ Contacted? _____

Prevention Education Appointment? _____ Case Management Appointment? _____

Please call New Vista's Regional Prevention Center with any questions at 859- 225-3296.

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Authorization for Release of Information

Health Information Management
650 High Street, Danville, KY 40422
Phone 859-238-7073 Fax 859-238-7731

Type of Release ☐ Permission to Discuss Care Only ☐ Paper Records Needed Only ☐ Permission to Discuss Care and Paper Records Needed

Client Name _____ **Date of Birth** _____ **SS#** _____

Dates of Health Information Being Requested: _____ Through _____

Please select the following information you would like to obtain:

☐ Evaluation/Assessment ☐ Progress Notes ☐ Treatment Plan(s) ☐ Lab Results ☐ E/M Notes
☐ Safety Plan(s) ☐ History/Physical Exam ☐ Medications ☐ Discharge Summary ☐ **Other (explain below)**

_____

The release of this information is for the purpose of: ☐ Use in future treatment ☐ Other (explain): _____

This release will expire sixty (60) days from the date below or on _____.

☐ Receive Information From ☐ Send Information To: _____
Name of Requesting Party

_____
Street Address **City** **State, Zip**

_____ _____
Phone **Fax**

- I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of psychiatric disorders/mental health, drug and/or alcohol use, HIV/AIDS or sexually transmitted diseases. If there is information pertaining to psychiatric disorders/mental health, drug and/or alcohol use, HIV/AIDS or sexually transmitted diseases in my medical record, you are specifically authorized to release it. I am giving this consent voluntarily and have been informed of the specific type of information that has been requested. Information may be released in written or verbal format. Benefits and disadvantages of releasing information have been explained to me. I understand that provision of service does not depend on my decision concerning the release of information.
- **PROHIBITION ON REDISCLOSURE:** According to 45 CFR 164.508 c2Ciii health information may be re-disclosed by the recipient. However, pursuant to **KRS 304.17A-555, *Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure*** mental health/chemical dependency info may not be used and/or shared by the recipient of said information unless specific, written consent for re-disclosure is authorized by the person to whom it pertains. Additionally, **Federal Regulations 42 CFR, Part 2** prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. If a general designation is identified for disclosure on this release, you have the right to obtain, upon request, a list of entities to which your information has been disclosed. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. You may report violations to the United States Attorney at 260 W. Vine St., Ste. 300, Lexington, KY 40507-1612 and/or to the Substance Abuse and Mental Health Services Administration office at 5600 Fishers Ln., Rockville, MD 20857.
- I understand I may revoke this authorization at any time by signing the bottom of this form. NewVista, however, cannot be responsible for any release(s) of information prior to notification or when required by law.

_____ _____
Today's Date Signature of Client

Parent/Guardian Signature is required for all minors age 17 years or younger. Please read the following information before signing.
I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.

_____ _____ _____
Signature of Client's Parent/Legal Guardian Relationship to Client Date

_____ _____
Signature of Witness ***(required on all releases)*** Date

***** **I wish to revoke the above authorization** *****

_____ _____
Date Signature

BG-MED-033 6/94 Rev. 12/98; 04/03 04/13; 06/14; 08/16; 10/16; 02/17; 06/2019