

**Referral to Howard County Hub and Spoke Care Coordination**

Full Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Race \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**Referral Source**

Referral Agency/Office: \_\_\_\_\_  
Address: \_\_\_\_\_  
Agency/Office Contact Person: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Date Referred: \_\_\_\_\_

**Insurance Provider:** \_\_\_\_\_

Active: \_\_\_\_\_ Lapsed: \_\_\_\_\_ Started Process: \_\_\_\_\_

**Housing Status:** *Check All That Apply*

Homeless \_\_\_ Living with Family/Friends \_\_\_ Temporary (Recovery House/Shelter/Couch Surfing) \_\_\_ Other: \_\_\_\_\_  
Howard County Resident: Yes \_\_\_ No \_\_\_  
Mailing Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
(Other) Emergency contact: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Reason for Referral (Services needed)** *Check All That Apply*

Peer Recovery Support \_\_\_\_\_  
Medicated Assisted Treatment (MAT) \_\_\_\_\_  
Mental Health Support \_\_\_\_\_  
Recovery Support \_\_\_\_\_  
Food/Housing/Clothing \_\_\_\_\_  
Substance Use \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_  
Health Insurance \_\_\_\_\_

**Psych History** *Client Must have a Primary Opioid Disorder*

Diagnostic Code: \_\_\_\_\_  
Other: \_\_\_\_\_  
Rx: \_\_\_\_\_



**Bureau of Behavioral Health**  
8930 Stanford Blvd | Columbia, MD 21045  
410.313.6202 - Voice/Relay  
410.313.6212 - Fax  
1.866.313.6300 - Toll Free  
hchealth.org/gethelp

Maura J. Rossman, M.D., Health Officer

**Treatment History**

Has client been started on MAT? \_\_\_\_\_

Last Known Usage (Days): 30\_\_ 60\_\_ 90+\_\_

Previous Treatment: \_\_\_\_\_

Inpatient: Yes\_\_ No\_\_

Discharge Date: \_\_\_\_\_

Previous MAT Treatment: \_\_\_\_\_

Dates: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosages: \_\_\_\_\_

*The patient certifies that the above information is correct to the best of their knowledge. The patient understands that the information provided in this referral will be disclosed to the Howard County Health Dept. Bureau of Behavioral Health and may be re-disclosed to the service providers for services listed above, not to include, medical or behavioral health confidential records. Therefore, the information provided by the patient in this referral form is no longer protected by any federal or state regulations regarding confidentiality and medical records. This referral expires 90 days from the date below.*

**Signature of patient confirming verbal consent:**

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

**Print Name:** \_\_\_\_\_

**\*Please return referral to: Hub & Spoke Coordinator, Thomas Benner**

Email: tbenner@howardcountymd.gov

Phone: 410.313.6281

Cell: 443.812.2758

Fax: 410.313.6212