CALVERT COUNTY HEALTH DEPARTMENT
LOCAL BEHAVIORAL HEALTH AUTHORITY
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STATE OF MARYLAND

Hub and Spoke Referral Form

Please attach the following (if applicable):

☐ ***Stability Criteria Form (for Spokes)***

☐ ***Signed release of information (ROI) (for transfers between Hub/Spokes)***

☐ ***Medical records, including treatment plan, contact notes, etc. (for transfers between Hub/Spokes)***

Client Information

Name: _____ **D.O.B:**_____

Gender: _____ **Race:** _____

Contact Number: _____

Address: _____

Other Populations *(Select all that apply)*:

- ☐ Pregnant
- ☐ Women with children
- ☐ Limited English proficiency
- ☐ Deaf and/or hard of hearing
- ☐ None of the above

Housing Status:

- ☐ Housed
- ☐ Transitional Housing
- ☐ Unhoused
- ☐ Other
- ☐ Declined to answer/Unknown

Veteran Status:

- ☐ Veteran
- ☐ Not a veteran
- ☐ Declined to answer/Unknown

Insurance Provider: _____

ID#: _____

☐ **Active** ☐ **Lapsed** ☐ **Uninsured**

Referral Source

Date of Referral: _____

Provider/Agency Name: _____

Address: _____

Referral Contact, & Title: _____

Office Number: _____

Reason for Referral *(Select all services needed)*:

- ☐ Case Management
- ☐ MOUD Treatment/Management
- ☐ Primary Care/Somatic Health Services
- ☐ Dental Services

- ☐ Peer Services (i.e., peer support services, group support, etc.)
- ☐ Mental Health Services (i.e., Psychiatric services, crisis services, intensive/outpatient services, etc.)
- ☐ Residential/Housing Services
- ☐ Employment (i.e., vocational training, resume assistance, etc.)
- ☐ Entitlements/Benefits (i.e., Medicaid, Food assistance, etc.)
- ☐ Other _____

Medication & Treatment History **To be enrolled in the Hub and Spoke program, the client is **required** to be diagnosed with an Opioid Use Disorder**

Is the client diagnosed with an Opioid Use Disorder (OUD)? _____
Diagnostic Code: _____
Last known use of opioids?

- ☐ 30 Days or less
- ☐ 2-3 Months
- ☐ 90 Days or more
- ☐ Declined to answer/Unknown

Has the client received MOUD before being referred to the Hub and Spoke program? _____
If yes, please indicate what medication was taken and when the client began taking medication. *(Please check from the list below):*

- ☐ Suboxone/Buprenorphine
  Start Date: _____
  Dosage: _____
- ☐ Methadone
  Start Date: _____
  Dosage: _____
- ☐ Naltrexone (Vivitrol)
  Start Date: _____
  Dosage: _____

_____ _____
Signature of Referral Agency Representative **Date**

_____ _____
Client Signature **Date**