

This is a referral packet system for Milestone Extended Care Services; our 9-month, 21-bed Men's residential program for substance use treatment located at 28 Portland Ave Old Orchard Beach, ME.

Individuals or referral sources can complete a referral packet online—including all relevant medical and psychiatric records—by visiting <https://milestone-recovery.org/residential>. Once the packet is completed, please fax it along with all supporting records to 207-934-5139. This new process replaces our previous phone screening system. After submitting the packet, please wait to be contacted by a staff member who will schedule a follow-up call to answer any questions and arrange an intake date.

If you have any questions about the new process, please email Melissa Gilman at mgilman@milestone-recovery.org. We understand the urgency of finding treatment and appreciate your patience as we manage a high volume of requests.

Please also note that to be eligible for this level of care, candidates must have a prior treatment history (a minimum of IOP or short-term residential treatment is sufficient). We DO NOT have medical staff on site and candidates must be medically stable, able to administer their own medications and have a PCP if they are prescribed medications. To assess eligibility we require medical records, including documentation of a current provider and records from any hospital visits, urgent care visits or specialists seen in the past year. Additionally, due to the daily clinical groups, individuals in the program will be unable to obtain employment for at least 6 months.



MILESTONE
RECOVERY

Milestone Recovery Extended Care Program

Referral Form

Client Name: _____ DOB: _____ Age: _____

Gender: _____ SSN # _____

Mailing Address: _____ City/Town: _____

State: _____ Zip Code: _____ County: _____

Current physical address _____

Phone: _____ Message Phone: _____

Referral date: _____

Referral Source (if not self): _____

Agency (If applicable): _____

Referral Source Phone: _____

*Reason for Referral/Challenges having in life:

Method of payment: MaineCare Sliding Scale

MaineCare #: _____

Current Medications (please list all meds and attach a current list from provider):

***Legal Status (probation, drug court, charges, sex offender registry, conditions of release that may interfere with treatment):**

***Health Concerns (please include any surgeries or procedures or Emergency Room/Urgent care visits in the past year):**

***Current Primary Care Physician (if none currently, who was the last):**

Current Dental Needs:

Cognitive or Physical Disabilities:

Ability to Read and Write: Yes

No

History of Substance Use with Age of First Use:

Date Last Used Substance:

Are you or have you ever been an IV drug user: yes_____ no_____

***History of Treatment Episodes (please include all outpatient and residential levels of care):**

Outcome of previous treatment episodes/How long was recovery sustained?

Mental Health Diagnosis (If known):

***Current Psychiatric Providers (if none current, please list most recent):**

***History of Psychiatric Hospitalizations or Emergency Room Visits due to Mental Health in the last year:**

Client Strengths:

Client Challenges that could negatively impact participation and completion of treatment:

***Please complete the attached release of information for all providers listed in these questions. No application will be approved for admission without reviewing previous medical records.**

For justice involved referrals, please include all medical and psychiatric records from your facility with this referral. Records can be faxed to 934-5139.



10 Andover Rd Portland, ME 04101
 Phone: (207) 775-4790
 Fax: (207) 775-5231

28 Portland Avenue Old Orchard Beach, Maine 04064
 Phone: (207) 934-5231
 Fax: (207) 934-5139

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Name:		DOB:		Last 4 SS#	
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I hereby authorize Milestone Foundation, its authorized employees and agents to: *(Check all appropriate boxes)*

Obtain written medical/clinical records: **Disclose** written medical/ clinical records: **Verbally** discuss:

(All Organization/ Address fields must contain information with the exception of the Fax #, in order for the Authorization to be compliant)

Organization/Individual:		Relationship:	
Street Address:		Phone:	
City/State/Zip:		Fax:	

This authorization applies to all Milestone Foundation programs that I am currently enrolled in or have been enrolled in unless program exclusion is noted: **DO NOT release information from following noted program(s):** _____

The medical/clinical records and information include the following: (mark with X only those items to be disclosed)

- Treatment Plan Psychological Testing Discharge Summary Psychiatric Evaluation Progress Notes
 Medical Info/Labs Medication List Diagnoses Comprehensive Assessment Financial Info
 Other Records (be specific): _____

The records and information are to be provided or obtained for purposes of: (Place an X next to all appropriate responses)

- Ongoing Treatment Educational Financial Coordination of treatment Aftercare Treatment Legal
 Other *(be specific)*: _____

1. **I DO** **I DO NOT** authorize information which refers to **treatment or diagnosis of alcohol or drug abuse** to be disclosed or obtained.

I understand that my records are protected under federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Re-disclosure of my records by those receiving the above authorized information may not be accomplished without my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent is in effect until:

 (maximum of one year for mental health services and ninety days for one time disclosures)

2. **I DO** **I DO NOT** authorize information concerning diagnosis and treatment of mental health conditions to be disclosed or obtained.
 3. **I DO** **I DO NOT** authorize information which refers to treatment or diagnosis of HIV infection or AIDS to be disclosed or obtained.
 4. **I DO** **I DO NOT** want to review these records prior to release.

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

Staff Signature and Title: _____ Date: _____

Printed Name: _____



REQUEST TO WITHDRAW RELEASE OF INFORMATION

I, _____ (Name), _____ (DOB),
_____ (Last four of SS#) do hereby request and authorize Milestone Recovery
to **withdraw** my consent to release/obtain information from:

Organization/Individual:		Relationship:	
Street Address:		Phone:	
City/State/Zip:		Fax:	

Signature: _____ Date: _____

Staff Signature and Title: _____

Printed Staff Name: _____ Date: _____