CALVERT COUNTY HEALTH DEPARTMENT
LOCAL BEHAVIORAL HEALTH AUTHORITY
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STATE OF MARYLAND

Hub and Spoke Self-Referral Form

To be enrolled into the Hub and Spoke program, you are required to be diagnosed with an opioid use disorder (OUD)

Date of Referral: _____

Client Information:

Name: _____ **D.O.B:** _____
Gender: _____ **Race:** _____
Contact Number: _____
Address/Current Living Situation: _____

Other Populations *(Select all that apply):*
- ☐ Pregnant
- ☐ Women with children
- ☐ Limited English Proficiency
- ☐ Dead 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#: _____
Status: ☐ Active ☐ Lapsed ☐ Uninsured

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 _____

History of Opioid Use:

Last known use of opioids?

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

Treatment History:

Have you ever been prescribed medication for the treatment of Opioid Use Disorder (MOUD), either currently or in the past? Examples include Buprenorphine, Methadone, or Naltrexone.

- ☐ Yes
- ☐ No

(If yes, please provide the following information below)

Name of Treatment Provider: _____
Phone Number: _____
Address/Location: _____
Please indicate what medications that you are currently taking or have taken in the past?

- ☐ Buprenorphine *(ex: Zubsolv, Suboxone, Sublocade, etc.)*
  Start & End Date *(if able)*: _____
  Dosage: _____
- ☐ Methadone *(ex: Methadose, Dolophine, etc.)*
  Start & End Date *(if able)*: _____
  Dosage: _____
- ☐ Naltrexone *(ex: Vivitrol, Depade, etc.*)
  Start & End Date *(if able)*: _____
  Dosage: _____
- ☐ Other: _____
- ☐ Unknown

Additional Comments: _____

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