Psychiatric Rehabilitation/Peer Support Services Referral Form

Fax: 814-867-1493 Attn: ASA

**PLEASE ATTACH A RELEASE OF INFORMATION FORM TO SKILLS OF CENTRAL PA

FIRST NAME: _____ MI: _____ LAST: _____

DATE OF REFERRAL: _____

ADDRESS:

_____

PHONE: DAY ( ) _____ EVENING ( ) _____

DATE OF BIRTH: _____ Current Age: _____ SOCIAL SECURITY #: _____

INSURANCE NAME: _____ INSURANCE #: _____

MA ID #: _____

GENDER IDENTIFICATION: _____ GUARDIANSHIP STATUS: _____

REFERRAL INFORMATION

REFERRING AGENCY: _____ PHONE: ( ) _____

NAME & TITLE OF PERSON MAKING REFERRAL:

_____

Referral being made to (check all that apply):

Opportunity Centre Clubhouse ☐ **(Centre County Only)** **Psych Rehab** ☐ **Peer Support** ☐

Domains: Check One Goal Area and specify anticipated client desired goal for that area. List specific skills needed in each:

☐ 1. Living

_____

☐ 2. Wellness

_____

☐ 3. Social

_____

☐ 4. Educational

_____

☐ 5. Vocational

_____

PSYCHIATRIC/MEDICAL HISTORY

Diagnosis: Please include a primary behavioral health diagnosis. *MUST USE ICD 10 Code*

Behavioral Health: Code _____ _____

Behavioral Health: Code _____ _____

Behavioral Health: Code _____ _____

Physical Health: _____

Physical Health: _____

Current Medical Providers

Psychiatrist:	Phone:
Primary Care Physician:	Phone:

Treatment History

☐	Currently resides in State Mental Hospital or discharged from State Mental hospital in past 2 years
☐	2 admissions to inpatient psychiatric unit or crisis residential totaling 20 or more days in past 2 years
☐	5 more face to face contacts with walk-in, mobile, or emergency services within the past 2 years
☐	1 or more years of continuous attendance in community mental health or prison psychiatric service within the past 2 years
☐	History of sporadic course of treatment, inability to maintain me regime or involuntary commitment to outpatient services
☐	1 or more years of mental health treatment provided by a PCP within the past 2 years

Coexisting Conditions:

☐	Psychoactive substance use disorder
☐	Intellectual Development Disorder
☐	Sensory Disability (specify):
☐	Developmental Disability (specify):
☐	Physical Disability (specify):
☐	Homelessness
☐	Release from criminal detention

Current legal concerns:

☐	Probation/Parole
☐	Mental Health Court
☐	Pending Charges

ATTACH/INCLUDE TREATMENT HISTORY AND MOST RECENT DISCHARGE SUMMARIES

I know a referral is being made and I agree to participate in services:

Participant Signature: _____Date: _____

Recommendation for SKILLS:
Psychiatric Rehabilitation/Peer Support Services

Person Served: _____ **Date:** _____

This form shall serve as official verification that the person served above fully meets the program and the Department of Public Welfare 55 PA Code 5230 for receiving Psychiatric Rehabilitation and Peer Support Services.

1. Primary Mental Health Diagnosis: _____ code: _____
   (***MUST USE ICD 10 Code*)**
   ☐ Qualifying diagnosis (schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder, borderline personality disorder.
   ☐ Exception diagnosis (primary mental health diagnosis) *****Diagnosis Exception (Individuals who do not meet the serious mental illness diagnosis requirement above can still receive services by documenting the current primary mental health diagnosis and completing question two).**

2. As a result of the mental illness the person has a moderate to severe functional impairment that interferes with or limits performance in at least one of the following areas (check one):

   ☐ **Social** ☐ **Self-Maintenance** ☐ **Education** ☐ **Vocational** ☐ **Living**

Please give a description of functional impairment that interferes with or limits performance the checked area as a result of the mental illness.

Signature of the Physician or other practitioner of the healing arts with credentials: (Psychiatrist, Physician, Physician Assistant, Certified Registered Nurse Practitioner, LCSW, LPC, LMFT, or Licensed Psychologist)

_____ **Date:** _____

Printed Name of Physician or other practitioner of the healing arts:

_____