# BERKS COUNTY PEER SUPPORT SERVICES REFERRAL FORM

Date of Referral:_____ Referring Agency:_____

Person Making Referral:_____ Contact #:_____

**Complete this form and fax to the agency of the member's choice with a signed Recommendation Form**

**Member must have MA to receive this service**

| Agency | Fax # | Ages | Specific populations served (if applicable) |
|---|---|---|---|
| ☐ Abilities In Motion | 610-376-0021 | 14+ | Physical disabilities |
| ☐ Berks Counseling Center | 610-373-3779 | 14+ | |
| ☐ Familicare | 610-898-0773 | 18+ | |
| ☐ Greater Reading Mental Health Alliance | 610-775-4000 | 16+ | |
| ☐ Service, Access, & Management, Inc. | 610-375-4457 | 18+ | Forensic |
| ☐ Threshold Rehabilitation Services | 855-708-4804 | 16+ | |

Member Name:_____

DOB:_____ SSN:_____ MA#: _____

Male / Female Identified Gender:_____ Preferred Gender Pronoun:_____

Primary/Preferred Language:_____ Marital Status: S / M / W / D / Sep

Home Address:_____

Home Phone:_____ Cell Phone:_____

Current Location/Address/Phone:_____

_____

Type of Living Situation (i.e. CRR, Independent, PCBH, Shelter, Supported Living, etc.):_____

Emergency Contact:_____ Relation:_____ Phone:_____

Medical Advanced Directive: Y / N Wrap Plan: Y / N

Psychiatric Advanced Directive: Y /N Crisis Plan: Y / N

PCP Practice:_____ MD Name:_____ Phone:_____

Case Management Agency:_____ Case Manager Name:_____ Phone:_____

Outpatient Agency:_____ Therapist Name:_____ Phone:_____

Psychiatrist Agency:_____ MD Name:_____ Phone:_____

Other Behavioral Health Services / Supports:_____

SUD: Y / N Explain:_____

Trauma History: Y / N Explain:_____

Legal (History and Current): Y / N Explain:_____

Probation/Parole: Y / N Name of Officer:_____ Phone:_____

**NAME:**_____ **MA#:**_____

Reason for Referral / Goals:_____

Diagnosis: **Must have the presence or history of a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED), including diagnosis (as defined in the current Diagnostic and Statistical Manual) and functional impairment.**

Behavioral Health:

Physical Health/Medical Conditions:

**One of the following categories must be met (A, B or C):**

**A. Treatment History:**

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

**B. Coexisting Condition or Circumstance with Mental Illness:**

- ☐ Psychoactive Substance Use Disorder, or
- ☐ Intellectual Disability, or
- ☐ HIV / AIDS, or
- ☐ Sensory Disability (Specify), or
- ☐ Developmental Disability (Specify), or
- ☐ Physical Disability (Specify), or
- ☐ Homelessness, or
- ☐ Release from Criminal Detention

**C. Involuntary Treatment Status:**

- ☐ Met standards for Involuntary Treatment in the past 12 months preceding this assessment

**Category D must be met:**

**D. Must have a moderate to severe functional impairment that limits performance in 1 of the following: Explanation of the impairment needs to be provided.**

- ☐ Educational _____
- ☐ Social _____
- ☐ Vocational _____
- ☐ Self-maintenance_____

Member Signature:_____ Date:_____

Referral Signature:_____ Date:_____