DICKINSON CENTER, INC.

PEER SUPPORT REFERRAL/ DOCTORS RECOMMENDATION

43 Servidea Drive, Ridgway, PA 15853

Phone: (814) 772-2005 ext. 422 Fax: (814) 772-4348

THE SECTION BELOW MUST BE FILLED OUT BY REFERRAL SOURCE.

NAME: _____ **DATE:** _____

ADDRESS: _____

HOME PHONE _____ **CELL PHONE** _____

BSU or MA ID# _____

REFERRAL SOURCE: _____ **SOCIAL SECURITY NUMBER:**_____

REFERRALS PHONE #: _____ **OTHER AGENCIES INVOLVED:** _____

BIRTH DATE:_____ **Must be age 18 or 22 if in Special Education**

Proof of behavioral health diagnosis code (F-CODE) such as Psychiatric or Psychological Evaluation must accompany this referral along with a release of information.

Must Meet One of the Categories A or B or C or D. Category E Must be Met. Please check box(es) that apply.

A. Treatment History:

	Currently resides in state mental hospital or discharged from a state mental hospital in the past 2 years
	2 admissions to inpatient psychiatric unit or crisis residential totaling 20 or more days in the past 2 years
	5 or 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 a community mental health or prison psychiatric service within the past 2 years
	History of sporadic course of treatment, inability to maintain med regime or involuntary commitment to outpatient services
	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		
	Mental Retardation		
	HIV/AIDS		
	Sensory disability	Specify:	
	Developmental disability	Specify:	
	Physical disability	Specify:	
	Homelessness		
	Release from criminal detention		

C. Global Assessment of Functioning rating is 50 or below

	IF **YES** LIST **GAF**_____
	No

D. Involuntary Treatment Status

	Met Standards for involuntary treatment in the past 12 months preceding this assessment.	Specify:	

PLEASE COMPLETE PAGE 2

Revised 9.1.2016

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E. **Must** have a moderate to severe functional impairment that limits performance in **at least 1** of the following: **Please check & describe.**

☐ **Educational** ***Describe this impairment*** _____

☐ **Social** ***Describe this impairment*** _____

☐ **Vocational** ***Describe this impairment*** _____

☐ **SELF-MAINTENANCE** ***Describe this impairment*** _____

Must have a diagnosis of a serious mental illness (SMI) as defined in the Mental Health Bulletin - Office of Mental Health 94-04 Serious Mental Illness: Adult Priority Group

DIAGNOSES: (Must have a diagnosis for Schizophrenia, Major Mood D/O, Psychotic Disorder NOS, or Borderline Personality D/O)

Behavioral Health Diagnosis & F CODE:

Behavioral Health Diagnosis & F CODE:

Behavioral Health Diagnosis & F CODE:

Medical Conditions/Physical Health Issues:

Medical Conditions/Physical Health Issues:

Psychosocial/Environmental Concerns:

MUST BE SIGNED BY A LICENSED PRACTIONER OF THE HEALING ARTS. Please circle which applies: Psychiatrist, Physician, Licensed Psychologist (PhD or M.A. level), Certified Nurse Practitioner (CRNP), Physician Assistant.

Signature:_____ **Credentials** _____

Printed Signature:_____ **Date:**_____

By signing this form, the Practitioner has reviewed the referral, attests to its accuracy, and recommends the above mentioned participant for the Peer Support Program with DCI.

Please fax COMPLETED PAGES (2) TO TRACEY WILLIAMS (814) 772-4348 ALONG WITH OTHER SUPPORTING DOCUMENTATION

Please contact Tracey Williams @ (814) 772-2005 ext. 422 or Julie Papa @ (814) 772-2005 ext. 421 for any questions.