Recovery Partnership – Peer Services Referral Form

70 W. North Street Bethlehem, PA 18018
Phone: (610) 861-2741 Fax: (610) 861-2781

Date Rcvd: ______________

New: _____ Reopen: _____

Name: ____________________ D.O.B.: ____________________

Address: ____________________ City: ____________ Zip: ________

Living Status: ☐ Independent ☐ With Family ☐ Roommate ☐ Supervised (CRR, PCBH, etc.) ☐ Homeless ☐ Shelter

County: ☐ Lehigh ☐ Northampton Gender: ☐ Male ☐ Female ☐ Transgender

Phone: ____________________ Social Security #: ____________________

Race: ☐ African American ☐ Caucasian ☐ Asian ☐ American Indian/Alaskan Native ☐ Other____________

Ethnicity: ☐ Hispanic/Latino Insurance: MA ID #: (ten digits) ____________________

Daily Activity: ☐ Competitive Employment ☐ Training/Education ☐ Work Program (APS, GSWS) ☐ Meaningful Activity ☐ No Activity	**Does the person have:** W.R.A.P. (Wellness Recovery Action Plan)? ☐ Yes ☐ No Psychiatric Advance Directive: ☐ Yes ☐ No

Psychiatric History/Supports:

Hospitalizations (Where & When?)____________________

Case Manager: ____________ Agency: ____________ Phone: ____________

Psychiatrist: ____________ Agency: ____________ Phone: ____________

Therapist: ____________ Agency: ____________ Phone: ____________

Primary Psychiatric Diagnosis: ____________________

Secondary Psychiatric Diagnosis: ____________________

Prescribed Medications: (include dosage and frequency)____________________

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____

____

Is the client able to self-administer medications as prescribed without supervision/support? ☐ YES ☐ NO

Does the person utilize the following to aid mobility: ☐ Cane/Crutches ☐ Wheelchair ☐ Walker ☐ Lanta Van

Medical Conditions: ____________________

____

Does the person need assistance with ADL's? ☐ Yes ☐ No Describe: ____________________

____

Current Stressors: ____________________

____

____

Emergency Contact: Name: ____________________

Relationship: ____________ Phone Number: ____________________

	History		Current	
Criminal Charges / Legal Issues	Yes	No	Yes	No
Alcohol / Drug Use	Yes	No	Yes	No
Suicidal Ideation / Suicide Attempt	Yes	No	Yes	No
Homicidal Ideation	Yes	No	Yes	No
Violence toward self or others	Yes	No	Yes	No

Please explain all YES answers: ____

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What does the person want to gain from peer support services?

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____

____

Check all that apply:

☐ Mood Changes Describe: ____

☐ Coping skills not working ☐ Disorganized Thinking ☐ Decreased ADLs ☐ Hears Voices ☐ Isolating

☐ Appetite: Increase/ Decrease ☐ Poor Concentration ☐ Racing Thoughts ☐ Irritability ☐ Grief / Loss

☐ Sleep: Increase/ Decrease ☐ Sadness / Hopelessness ☐ Poor Motivation ☐ Fears: ______________________

The person is aware that a referral for Peer Specialist services has been initiated and that Recovery Partnership has their permission to contact him/her or the emergency contact in regards to this referral.

☐ YES ☐ NO

The following documents are needed to complete the referral process:

☐ Peer Support Recommendation Form – Signed by an M.D., D.O.; Certified Registered Nurse Practitioner (CRNP), Physician's Assistant (P.A.) or Licensed Psychologist

☐ Current PsycoSocial History – or recent Progress Note from Psychiatrist which includes diagnosis.

☐ Reflections Supplemental Information Form - if client is interested in the 24 hour site-based peer respite services

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Signature of Person Completing Referral Form **Date**

____

Agency **Phone**