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 #: _____

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) _____

_____

_____

_____

Is the person 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: _____

_____

_____

_____

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: _____

How does the person plan to utilize peer support services?

_____

_____

_____

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 regarding 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 Psychosocial 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

_____ _____

Signature of Person Completing Referral Form **Date**

_____

Agency **Phone**

Certified Peer Support Recommendation Form

Date: _____

Client Name: _____ D.O.B.: _____

Due to current symptoms, the above individual is experiencing moderate to severe impairment in one or more major life areas. Therefore, he/she is being recommended for Certified Peer Specialist services.

Diagnosis: _____

ICD – 10 Code: _____

Secondary Diagnosis: _____

ICD – 10 Code: _____

_____ _____

Signature of Licensed Practitioner of the Healing Arts Date

Printed Name: _____

Address: _____

_____

Phone #:_____

Please Note: *A licensed practitioner of the healing arts consists of either a physician, physician's assistant, certified registered nurse practitioner, psychologist, licensed clinical social worker, licensed professional counselor, and licensed marriage and family therapist.*