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**

Recovery Partnership
Peer Services Program

70 West North Street, Bethlehem, PA 18018
Office: (610) 861-2741 Fax: (610) 861-2781

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.*

Recovery Partnership: Reflections Referral

Supplemental Information Form

1360 Main Street
Hellertown, PA 18055

ph: (610)748-1011
fx: (610)748-1012

For RP staff only
Date Reviewed: _____ Initials:_____

1. Person Referred: _____

2. Is the person able to take their medications as prescribed **without** supervision or support?

   ☐ YES ☐ NO ☐ Not Applicable

3. Reflections does not provide food as part of the program. The client is responsible for bringing food with them to the program. Does he/she have adequate resources to address nutritional needs?

   ☐ YES ☐ No ☐ Plan to utilize food bank prior to admission ☐ Other: _____

4. Can the person prepare his/her own food or is he/she able to ask for assistance? ☐ YES ☐ NO

5. Person's Preferred Language: _____

6. Does the person have access to transportation if needed for appointments, etc? ☐ YES ☐ NO

   If YES, please describe (personal vehicle, LANTA pass, ICM, etc): _____

7. If homeless, have referrals been made to housing programs, shelters, etc.?

   ☐ YES ☐ NO ☐ Not Applicable *If YES, where?* _____

   _____

8. Does the person require active supervision (parole/probation)? ☐ YES ☐ NO ☐ N/A

   If YES, describe recent criminal history: _____

   _____

   Name of P.O.:_____ *Phone Number*: _____

Additional Comments: