



# **RECOVERY PARTNERSHIP**

## **Certified Peer Specialist Referral Form**

64 W. North Street, Suite 101 Bethlehem, PA 18018  
Phone: (610) 625-2575 Fax: (610) 861-2781

Name: _____		D.O.B.: _____	
Address: _____		County: _____	
_____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Phone #: _____		Social Security #: _____	
<b>Living Status:</b> <input type="checkbox"/> Lives Independently <input type="checkbox"/> Lives with Family <input type="checkbox"/> Lives with Others <input type="checkbox"/> Supported Living <input type="checkbox"/> Restrictive Setting <input type="checkbox"/> Supervised Setting (CRR, PCBH, MR-CLA) <input type="checkbox"/> Homeless; Shelter/Mission		<b>Race:</b> <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Other	
		<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
<b>Relationship Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Engaged <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		<b>Financial Information:</b> Insurance: _____ MA ID #: _____	
<b>Vocational/Educational Activity:</b> <input type="checkbox"/> Competitive Employment <input type="checkbox"/> Training/Education <input type="checkbox"/> Work Program (APS, GSWS) <input type="checkbox"/> Meaningful Activity <input type="checkbox"/> No Activity		<b>Reason for Referral:</b> <input type="checkbox"/> Education <input type="checkbox"/> Vocational <input type="checkbox"/> Social <input type="checkbox"/> Self Maintenance How can peer services assist the individual (i.e. goals) ? _____ _____ _____ _____	
Has the person developed a crisis plan or wellness recovery action plan (WRAP) ? <input type="checkbox"/> Yes <input type="checkbox"/> No What is the overall goal? _____ _____ _____			
Does the person have a substance use history? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe: _____ _____			
List current services and/or supports: (i.e. community, family, drug & alcohol, agency supports) _____ _____			
List Current Medications including <u>dosage &amp; frequency</u> : <input type="checkbox"/> See attached medication list _____ _____			
Does the person have a history of violence toward self or others? Describe: _____			
Is the person a current risk of danger to self or others? <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>1. Must meet age from this section to continue.</b>  <input type="checkbox"/> <b>Age &gt; = 18 yrs old</b>	<input type="checkbox"/> <b>2. Has met the standards for involuntary treatment (as defined in Chapter 5100 Regulations – Mental Health Procedures) within 12 months preceding the assessment is automatically assigned to the high priority group. {If this box is checked, stop here, meets priority group standard and qualifies for peer support}</b>
<b>3. Axis I Specify Qualifying Diagnosis:</b> _____ 295.xx Schizophrenia      296.xx Major Affective Disorder      298.9x Psychotic Disorder NOS 301.83 borderline personality disorder <i>{If Adult Priority Group is not applicable; person is not considered to meet state definition of priority group. Refer to exception request process if applicable}</i>	

Must meet one of the following A, B or C. Check the criteria within the column that meets the standard:

<input type="checkbox"/> <b>A</b> <b>Treatment History</b>	<input type="checkbox"/> <b>Current Residence in or discharge from a state mental hospital within past 2 years</b> <input type="checkbox"/> <b>Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days within the past two years</b> <input type="checkbox"/> <b>Five or more face to face contacts with walk in or mobile crisis or emergency services within the past two years</b> <input type="checkbox"/> <b>One or more years of continuous attendance in a community mental health or prison psychiatric service (at least one unit of service per quarter) within the past two years</b> <input type="checkbox"/> <b>History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services</b> <input type="checkbox"/> <b>One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician, (e.g. Area Agency on Aging) within past two years</b>
<input type="checkbox"/> <b>B</b> <b>Functioning Level</b>	Fill in GAF score _____ <i>Global Assessment of Functioning Scale rating of 50 or below</i>
<input type="checkbox"/> <b>C</b> <b>Coexisting Condition or Circumstance</b>	<input type="checkbox"/> <b>Coexisting Diagnosis</b> <input type="checkbox"/> <b>Psychoactive Substance Use Disorder</b> , <input type="checkbox"/> <b>Mental Retardation, HIV/AIDS, Sensory, Development and/or Physical Disability</b> {check if SA or MR} <input type="checkbox"/> <b>Homelessness</b> (sleeping in shelters or places not meant for human habitation, such as cars, parks, sidewalks, or abandoned buildings) <input type="checkbox"/> <b>Release from Criminal Detention</b> (applicable categories of release from criminal detention are jail diversion; expiration of sentence or parole; probation or Accelerated Rehabilitation Decision [ARD])

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**

**Psychiatric Evaluation – Completed within the last 12 months**

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ May we contact:  Yes  No

I, \_\_\_\_\_, understand that I am being referred to Recovery Partnership, for Peer Support Services. I give permission to have someone from Recovery Partnership Peer Services Program call me to set up the initial appointment.

\_\_\_\_\_  
Signature of person referred to Peer Services Program

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Phone #