

# FAMILY PSYCHOLOGICAL

*Together With Kids Count Inc*

625 RUSTIC LODGE ROAD  
SUITE C  
INDIANA, PA 15701

FAMILY PSYCHOLOGICAL ASSOCIATES

PH. 724.349.6320  
FAX 724.349.6359

IMPROVING LIVES IN OUR COMMUNITY

## Blended Case Management Referral

I. IDENTIFYING INFORMATION			
Date of Referral		Consumer Name	
Date of Birth		Age	
Current Address		Phone	
MA #		Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed
SSN		Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of Homelessness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	In School	<input type="checkbox"/> Yes <input type="checkbox"/> No           If yes, list grade:
For Children: Parent/Guardian		IEP	<input type="checkbox"/> Yes <input type="checkbox"/> No

II. REFERRAL SOURCE			
Person Making Referral (Name & Title)		Phone	
Representing Agency			
Date & Time of Next Outpatient Appoint.			

III. DSM IV DIAGNOSIS			
Diagnosed by		Date	
Axis I			
Axis II			
Axis III			
Axis IV			
Axis V			

IV. SERVICE NEEDS THAT REQUIRE COORDINATION : Please Be As Specific As Possible	
MH Treatment:	
Housing/Living:	
Education/Employment:	
Support System:	
Basis Activities of Daily Living	
D&A Treatment::	
Medical Treatment:	

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

MA#: \_\_\_\_\_

V. SERVICE PROVIDERS INVOLVED WITH THIS CONSUMER						
Type of Service						
<input type="checkbox"/> CYF	<input type="checkbox"/> Partial Hosp.	<input type="checkbox"/> OP MH	<input type="checkbox"/> OP D/A	<input type="checkbox"/> Psych Rehab	<input type="checkbox"/> Mobile Medications	
<input type="checkbox"/> Social Security	<input type="checkbox"/> Education	<input type="checkbox"/> LTSR	<input type="checkbox"/> OVR	<input type="checkbox"/> D/A CM		
<input type="checkbox"/> Inpatient/ Out of Home placement			<input type="checkbox"/> Strength Based Treatment		<input type="checkbox"/> IOP	
<input type="checkbox"/> FBMHS	<input type="checkbox"/> BHRS	<input type="checkbox"/> RTF	<input type="checkbox"/> WIC	<input type="checkbox"/> JPO	<input type="checkbox"/> Adult Probation	
<input type="checkbox"/> Clozaril & Support Services		<input type="checkbox"/> Methadone	<input type="checkbox"/> Housing			
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		

VI. PREVIOUS PSYCHIATRIC HOSPITALIZATIONS	
Facility	Dates (From – To)

VII. ADULT TREATMENT HISTORY	
<input type="checkbox"/> Six or more days of inpatient mental health treatment in the past 12 months	<input type="checkbox"/> Met 302 standards in past 12 months
<input type="checkbox"/> At least three missed community mental health service appointments or documentation the individual has not maintained his/her medication regimen for a period of at least 30 days	<input type="checkbox"/> Two or more face-to-face with crisis intervention in past 12 months
<input type="checkbox"/> Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems	<input type="checkbox"/> History of State Hospitalization within past 12 months. Discharge Date: _____
<input type="checkbox"/> Adults who were receiving case management services as children	<input type="checkbox"/> <b>Adults</b> - GAF 60 and below

VIII. CHILD AND ADOLESCENT TREATMENT HISTORY	
<input type="checkbox"/> Six or more days of inpatient mental health treatment in the past 12 months	<input type="checkbox"/> Met 302 standards in past 12 months
<input type="checkbox"/> Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems	<input type="checkbox"/> Without case management services would result in out- of- home placement
<input type="checkbox"/> <b>Children/Adolescents</b> - GAF 70 or below	

**NOTE: Please include a copy of a signed evaluation that will substantiate the DSM IV diagnosis.**