HUMAN SERVICES, INC.

Peer Support Program REFERRAL

520 East Lancaster Avenue,
Downingtown, PA 19335

Phone 610-873-1005
Fax 610-873-3317

Name:_____ Case #:_____Date:_____
Address:_____
DOB_____SS#_____ Phone_____
Client's Rehabilitation Interests_____
Strengths_____ Deficits_____

SOURCE OF INCOME: Public Assistance_____ SSI:_____ SSD:_____ VA:_____ Job:_____
Other:_____ Amount:_____ MA Recipient #_____
Medicare ___A ___B _____Private Insurance/HMO_____ID#_____
No Insurance/County Pay_____ CCBH_____
Current Living Arrangement: CRR___ SLA ___ Independently_____ Family___ Other_____

MOST RECENT HOSPITALIZATION:

Where?	Admit Date	D/C Date

CURRENT TREATMENT SERVICES: INCLUDE MH AND D&A
Agency_____Address_____ Ph_____
Case Manager+ph_____Therapist+ph_____ __
Psychiatrist_____ Other services and provider's +ph# _____
_____
PCP_____ _____Phone #_____

PSYCHIATRIC DIAGNOSIS: (Complete all 5 Axes)
Axis I:_____ _____ _____
Axis II:_____ _____ _____
Axis III:_____ Axis IV:_____ GAF_____

USE OF DRUGS/ALCOHOL:
Substance_____ Length of use_____ Time sober_____
D&A treatment?_____ AA/NA_____
Incidences of Violence, Arrests, Prison, Probation_____

SIGNATURE:_____ DATE:_____
REFERRING PERSON:_____PHONE:_____

***Must have a recommendation from a Physician, Physician's Assistant, Certified Registered Nurse Practitioner, or Psychologist. (This can be noted in an evaluation, discharge recommendation or signature as referring person.)**

***Include a recent legible psychiatric evaluation with referral. Send or fax to Kristine Vuocolo**

Revised 7/2013