

**Service Coordination Referral for
Allegheny County Provider
Adult**

Consumer Name:		Date of Referral:	
Previous Name(s):			
DOB:	SSN:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race/ Ethnicity:	Primary Language:	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widow <input type="checkbox"/> Domestic Partner
Are you a Veteran:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Year and type of discharge:	
Current Address:			
Phone Number:		Best time to call:	
Financial Information/Source of Income			
Monthly Income Amount:			
<input type="checkbox"/> Employment	<input type="checkbox"/> SSI	<input type="checkbox"/> SSDI	<input type="checkbox"/> Public Assistance <input type="checkbox"/> VA <input type="checkbox"/> Retirement
<input type="checkbox"/> Alimony	<input type="checkbox"/> Child Support	<input type="checkbox"/> Other (please describe)	
If applied for and not yet receiving potential source of income, please describe and give date of application:			
Do you currently have a Representative Payee:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Provide Name and contact Information:	
Health Insurance Information			
Medical Assistance:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare:	<input type="checkbox"/> Yes <input type="checkbox"/> No Other: (please describe)
Emergency Contact Information			
Name:		Relationship:	
Address:			
Phone Number:			
Do you have a Guardian:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please provide Name and contact information:	
Referral Source			
Person making Referral (Name and Title):			
Representing which Agency/committee:			
Address:			
Phone:	Fax:	Email:	
Relationship to Consumer:			
Is Service Participant in Agreement with Referral:		<input type="checkbox"/> Yes <input type="checkbox"/> No (If no please explain)	

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Mental Health Information

DSM IV Diagnosis

Diagnosed by:		Date:	
Axis I:			
Axis II:			
Axis III (Medical Condition/problem):			
Axis IV (Stresses):			
Axis V: GAF Current		GAF Highest level in past 12 months	
Please attach a recent Psych Eval or Doctor's Signature to verify Diagnosis			

Risk Factors: (Explain Below as necessary)	Unknown	Yes	No
Suicidal (Ideation, Attempt)			
Physical Harm to Others			
Victimization of Others			
Destruction of Property			
Fire Setting			
Sexually Abusive/Inappropriate to Others			
Reckless Behavior possibly leading to physical harm to self or others			
Other: (Explain)			

CSP (If yes, please attach CSP Plan)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ACSP (If yes, please attach ACSP Plan)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Reason for Referral – Please indicate how Service Participant could benefit from Service Coordination:

Eligibility Criteria

- I. Diagnosis** (Diagnosis of Schizophrenia or Mood Disorder or any other Axis I diagnosis in the DSM IV excluding MR or Psychoactive Substance Abuse, Organic Brain Syndrome or V Code):
- II Treatment History: Must have one of the following**
- Admission to State Hospital totaling 60 days within the past 2 years
 - Six or more days of inpatient psychiatric hospital within the past year
Provide Dates:
 - Met standards for involuntary inpatient admission within past year
Provide Dates:
 - Two or more face-face contacts with emergency personnel within past year
(i.e. After hours, Crisis Services, ER Visits, Police)
 - Sporadic Treatment history such as missed three or more CMHC appointments or has not maintained medication regimen for 30 days
 - Transfer from another Blended Service Coordination Provider

III. GAF (must have a GAF of 60 or Below)

Referral Source Signature/Date: