



ALLEGHENY COUNTY OFFICE OF BEHAVIORAL HEALTH RESIDENTIAL REFERRAL FORM

Scan and Email referrals to obh-centralizedreferrals@alleghenycounty.us

SECTION I. IDENTIFYING INFORMATION

Consumer's Name:				Date:	
Date of Birth:		SS#:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Current/temp Address:		City:		Zip:	
The above address is where the consumer resides at time of referral: CRR, Homeless, IP/MH, RTF, Jail, Juvenile Det. etc					
Race		<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native Am/Alaskan	<input type="checkbox"/> Other
		<input type="checkbox"/> African Am	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Pacific Islander	
Consumer Phone Number:			eCaps:		
Priority Category		<input type="checkbox"/> Inpatient with disposition	<input type="checkbox"/> Inpatient/MH	<input type="checkbox"/> DAS/RTP	<input type="checkbox"/> ACSP
		<input type="checkbox"/> Criminal Detention	<input type="checkbox"/> CSP/CIT	<input type="checkbox"/> RTFA	<input type="checkbox"/> Deaf
		<input type="checkbox"/> TSH/Forensic Diversion	<input type="checkbox"/> TSH	<input type="checkbox"/> LTSR	<input type="checkbox"/> EAC
				<input type="checkbox"/> TRU	<input type="checkbox"/> CYF
				<input type="checkbox"/> CRU	<input type="checkbox"/> RTF
				<input type="checkbox"/> None	
Eligibility		<input type="checkbox"/> HealthChoices		<input type="checkbox"/> Medical Assistance	
				<input type="checkbox"/> N/A	

SECTION II. RECOMMENDED LEVEL OF CARE----SELECT ONLY *ONE*

LEVEL OF CARE	SITE PREFERENCE (IF ANY)
1. <input type="checkbox"/> CMHPCH	
2. <input type="checkbox"/> LTSR (If CTT is involved-complete section B on page 2)	
3. <input type="checkbox"/> CRR Apartment (If CTT is involved-complete section B on page 2)	
4. <input type="checkbox"/> CRR Group Home (If CTT is involved-complete section B on page 2)	
5. <input type="checkbox"/> MISA Group Home (If CTT is involved-complete section B on page 2)	
6. <input type="checkbox"/> 24/7 Supportive Housing	
7. <input type="checkbox"/> Specialized Residence	
8. <input type="checkbox"/> Personal Care Home (MYCS Senior Care Plaza Only)	McKeesport (4 th floor)
9. <input type="checkbox"/> Dom Care CHS (Lawn Street Only)	Oakland (CHS Only)
Is there an area/location where consumer <u>WOULD NOT</u> want to reside?	

Mobility Status:	<input type="checkbox"/> Ambulatory (able to walk)	<input type="checkbox"/> Utilizes a Wheel Chair	<input type="checkbox"/> Utilizes a Walker	<input type="checkbox"/> 1 st floor
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SECTION III. REFERRAL SOURCE INFORMATION

Referral Source Name:		Phone:	
Referral Source Email		Cell:	
Referral Source Title:	<input type="checkbox"/> Re:solve Staff	<input type="checkbox"/> CRU Staff	<input type="checkbox"/> EAC Staff
	<input type="checkbox"/> RTFA Staff	<input type="checkbox"/> Inpatient	<input type="checkbox"/> TRU Staff
	<input type="checkbox"/> Other:		
Referral Source Agency	<input type="checkbox"/> Press. Ridge	<input type="checkbox"/> Staunton	<input type="checkbox"/> WPIC-SC
	<input type="checkbox"/> Milestone	<input type="checkbox"/> Chartiers	<input type="checkbox"/> NHS-CTT
	<input type="checkbox"/> Other		
If CTT, What is the team #			

SECTION IV. LEVEL OF CARE JUSTIFICATION PAGE

If consumer has Service Coordination or being referred to (SC, ECSC, Acute) complete **Section A**

If consumer has CTT and is not being referred to an LTSR or CRR complete **Section A**

If the consumer has CTT and is being referred to an LTSR or CRR, complete **Section B**

Section A

Clearly State why the selected level of housing is needed at this time.

1.

2.

3.

4.

5.

6.

Section B

Why does the consumer need a CRR or LTSR

1.

2.

3.

List the top 3 supports/services that you will be providing differently from the CRR/LTSR

1.

2.

3.

List the top 3 goals that will assist consumer with discharge from the CRR/LTSR

1.

2.

3.

SECTION V. PSYCHOSOCIAL HISTORY

A. CURRENT LIVING ARRANGEMENT & FAMILY HISTORY

Consumer Name:		Age:	Birthdate:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow		# of children		
Permanent Address:		City	Zip:	
Current Whereabouts' (program, independent housing etc)				
Emergency Contact Person:		Emergency Contact #:		
Guardian:		Guardian Phone #:		
Representative Payee:		Rep Payee Phone#:		
Previous/Current County Housing Programs (ie CRR, LTSR, Supportive housing etc)				
Program Name		Date From	Date To:	

B. VOCATIONAL/EDUCATIONAL HISTORY (check all that apply)

Education Level	# of Years completed	Subject	Graduation Date
<input type="checkbox"/> High School			
<input type="checkbox"/> Vocational School			
<input type="checkbox"/> College			
<input type="checkbox"/> GED			

C. EMPLOYMENT HISTORY

Dates	Employer	Position

D. MILITARY HISTORY

Has consumer ever served in the military <input type="checkbox"/> Yes <input type="checkbox"/> No (Check all that applies)	
<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air force <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Honorable D/C <input type="checkbox"/> Less than Honorable D/C	

E. TREATMENT HISTORY

DSM Diagnosis: *DSM- psychiatric diagnosis other than primary alcohol or drug disorders, organic brain syndromes, developmental disabilities, or social conditions).*

Axis I:		
Axis II:		
Axis III:		
Axis IV:		
Axis V: GAF Current:	GAF Highest level in past 12 months:	IQ (if I.D.)

Current Psychiatric Services	Name	Phone Number	Agency
<input type="checkbox"/> Psychiatrist			
<input type="checkbox"/> Outpatient Therapist			
<input type="checkbox"/> Day Programming			

Psychiatric Hospitalizations Past 12 months (attach additional pages if needed)	Admission	Discharge
1)		
2)		
3)		

Psychiatric Medications (attach additional pages if needed)	Dosage
1)	
2)	
3)	
4)	

Service Coordination Services			
Level of Service	Contact Name	Phone Number	Agency
<input type="checkbox"/> SC <input type="checkbox"/> CTT <input type="checkbox"/> ECSC <input type="checkbox"/> DDTT			
Email Address:			
1. If not enrolled, has a referral been sent to an SC; CTT; ECSC, DDTT team for consideration <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Date referral was made:	Contact Person:	Phone #	
3. If no, reason why referral has not been made:			

F. Physical Health:

Indicate medical conditions such as diabetes, surgeries, heart disease, allergies, or other medical conditions
1)
2)
3)
4)
5)
6)
List Physical Health Medication (attach additional sheets if needed)
1)
2)
3)
4)
5)
6)

Can consumer manage own medication: Yes No

List all specialist ie cardiologist, gynecologist, oncologist, neurologist... (Attach additional pages if needed)		
Specialty Category	Condition being treated	Dr. Name and Number

List all special needs ie dialysis, oxygen, dietary restrictions (attach additional pages if needed)	
Special Needs	How often needed

G. SUBSTANCE USE HISTORY

Does the consumer have a history of substance use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the consumer currently using drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Type	Frequency/Amount	Date Of Last Use
<input type="checkbox"/> Alcohol		
<input type="checkbox"/> Amphetamines		
<input type="checkbox"/> Cannabis		
<input type="checkbox"/> Cocaine		
<input type="checkbox"/> Hallucinogens		
<input type="checkbox"/> Inhalants		
<input type="checkbox"/> Nicotine		
<input type="checkbox"/> Opioids		
<input type="checkbox"/> PCP		
<input type="checkbox"/> Sedatives/Hypnotics		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

List any previous drug/alcohol rehabilitation facilities (attach additional sheets if needed)	Admission Date	Discharge Date
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

H. LEGAL HISTORY (Attach additional sheets if needed)

Past, Current, and Pending Charges	Arrest Date	Release Date	Convicted
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Probation <input type="checkbox"/> Parole Officer:		Phone number	
<input type="checkbox"/> JRS Worker:		Phone number	
<input type="checkbox"/> JPO Worker		Phone number	

If JRS is involved, Is there a service plan? Yes No (Please Provide at the time of interview/tour)

I. ACTIVITIES OF DAILY LIVING: Does the consumer have difficulties with basic and Instrumental ADLs as a result of his/her mental or emotional disorder?

On a scale of 1 to 10 with 1 being " very difficult " and 10 being " very well " rate how well the consumer is able to complete the following tasks:		
Task	Score	Unknown
Prepare and cook for self?		<input type="checkbox"/>
Feed Self		<input type="checkbox"/>
Select Proper Attire & Putting on clothes		<input type="checkbox"/>
Adequately takes care of his/her personal grooming (shower/bathing, deodorant)		<input type="checkbox"/>
Maintain continence		<input type="checkbox"/>
Walking and transferring (such as moving from bed to wheelchair)		<input type="checkbox"/>
Manage financial matters independently?		<input type="checkbox"/>
Maintain housekeeping tasks? (basic housework)		<input type="checkbox"/>
Travel independently on public transportation or driving own car?		<input type="checkbox"/>
Take medication as prescribed?		<input type="checkbox"/>
Launder own clothes?		<input type="checkbox"/>
Shopping		<input type="checkbox"/>
Prepare meals		<input type="checkbox"/>
Attends to OP treatment, D& A		<input type="checkbox"/>

J. ECONOMIC STATUS

Source of Income (Check all that apply, and monthly amount:

Source of Income	Monthly Income
<input type="checkbox"/> Employment	\$
<input type="checkbox"/> SSI	\$
<input type="checkbox"/> SSDI	\$
<input type="checkbox"/> Child Support	\$
<input type="checkbox"/> Alimony	\$
<input type="checkbox"/> Veterans Benefits	\$
<input type="checkbox"/> Retirement	\$
<input type="checkbox"/> None:	\$
<input type="checkbox"/> Other: (Describe)	\$

If consumer does not have a source of income, how will rent or other expenses be paid for them in the interim?

If SSI or SSDI has been applied for the consumer, when was the application made and or appeal date?

K. RISK FACTOR INFORMATION

Risk Factors: (Each section must be checked)	Unknown	Yes	No
Suicidal (Ideation, Attempt): Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Harm to Others: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Victimization of Others: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destruction of Property: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire Setting: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Abusive/Inappropriate to Others/Indecent Exposure: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of being Sexually or Physically abused Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Megan's Law: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reckless Behavior possibly leading to physical harm to self or others: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gang involvement: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to weapons: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

L. INTELLECTUAL DISABILITY INFORMATION (Complete if consumer is intellectually disabled)

Name of Supports Coordinator:		Agency:
Address:		
Phone Number:	E-mail Address:	
Name of Supervisor:	Supervisor's Phone Number:	

County OID Contact Name:	Phone Number:

Current Funding Status:	PUNS Status:
<input type="checkbox"/> Base <input type="checkbox"/> PFD <input type="checkbox"/> Consolidated	<input type="checkbox"/> Emergency <input type="checkbox"/> Critical <input type="checkbox"/> Planning <input type="checkbox"/> All Needs Met

ISP Update Completed?	Level of ID:
<input type="checkbox"/> No <input type="checkbox"/> Yes – Date:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound

Current ID Services In Place	
Service in place:	Provider Agency
Provider Contact Information:	
Service in place:	Provider Agency
Provider Contact Information:	
Service in place:	Provider Agency
Provider Contact Information:	

Employment Status:	
<input type="checkbox"/> Community Employment <input type="checkbox"/> Pre-Vocational <input type="checkbox"/> Other (Explain):	
Employer:	Contact Person / Phone Number:
Address:	

CONSUMER SIGNATURE PAGE

*****This Section Must be completed prior to submission of referral*****

I _____ have discussed this Residential Referral
Consumer's Name (print)

with my Treatment Team and **I am in agreement** with this referral and agree to the Level of
Care being recommended. I can be reached at _____ for
(Phone Number)

further discussion if needed by the Office of Behavioral Staff.

Consumer's Signature

Date

A SIGNATURE IS REQUIRED ON THIS PAGE INDICATING THAT CONSUMER IS AGREEABLE TO THE LEVEL OF CARE BEING REQUESTED. REFERRALS WILL NOT BE PROCESSED WITHOUT THE CONSUMER'S SIGNATURE.

**LONG TERM STRUCTURED RESIDENCE (LTSR) CERTIFICATE
(Must be completed for admission into an LTSR)**

I, _____ am
(Name of Doctor)

recommending that _____
(Name of Consumer)

will be most appropriately placed in a Long Term Structured Residence at this time.

The consumer will not be admitted to a Long Term Structured Residence if he/she is in need of hospitalization, nursing facility or a level of care more restrictive than a Long Term Structured Residence at that time.

(Doctor's Signature) _____
(Date)

Commitment Status: _____

Expires on: _____

ALLEGHENY COUNTY OFFICE OF BEHAVIORAL HEALTH RESIDENTIAL CHECKLIST

***All documents must be presented
at the time of the interview***

The following items are required for admission into a residential program

- Allegheny County Residential Referral form
- A Signed Psychiatric Evaluation stating the current diagnosis. Must be current within 6 months of admission into an LTSR, 1 year for CMHPCH. CRR apartment, CRR Group Home, PCH, MISA, and 2 years for Supportive Housing.
- A Signed Physical Exam. Must be current within 6 months of admission into an LTSR, MISA, CRR Apartment, CRR Group Home, PCH and 2 years for Supportive Housing. MA-51 completed within 60 days prior to admission for CMHPCH.
- Psychosocial history must be completed within 1 year of admission for all programs. This must include vocational/educational, AOD and mental health histories. (Included in the referral packet)
- Laboratory testing for Tuberculosis (TB). If test is positive then a chest X-Ray is required. Test results must be current within 6 months of admission into any program.
- Proof of income is required for all levels of care.
- LTSR Only** : A Level of Care Physician Statement must be signed and dated by psychiatrist within 30 days of admission. An LTSR Admission Statement must be signed and dated by a treatment team member within 30 days of admission. (found in referral packet). A copy of commitment form (304, 305 or 306) is required.
- CMHPCH & PCH**: An MA-51 and an ARL-55 form must be signed by doctor 60 days prior to admission. Preadmission Screening Form is to be completed 30 days prior to admission. The Personal Care Home Assessment is to be completed within 15 days prior to admission.