Residential Services

2201 East State Street, Hermitage, PA 16148
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Libby Purdy: Residential Manager
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Referral Form
(MUST be completed in full)

Service Requested:

_____CRR _____Respite _____Supportive Housing

Name of Referral:_____

Address:_____

BSU#:_____ **Phone:**_____

SS#:_____ **DOB:**_____

Referred by:_____ **Agency:**_____

Date Referred:_____ **Agency Phone Number:**_____

**** Reason for Referral:**_____

_____

_____

Sex: M_____F____ Marital Status: M___S____Div._____Wid.___Other_____

Size of Household:_____

# of Children:_____**Children living with Referral: Yes_____No___**

Current Living Arrangements:

Temporary_____Permanent_____State Hospital_____

Independent_____Homeless_____Correctional Facility_____

PCBH_____With Family_____Other_____

Has the referral ever been evicted? Yes_____ No_____

Why were they evicted?_____

Is the referral currently employed or are they currently attending school of any type?

Where:_____

Education Completed (Grade) 7 8 9 10 11 12 Other_____

Religious Preference:_____

Income (Source/Monthly):_____ **Medical coverage:**_____

Source of Transportation:_____

Community Integration: (clubs, volunteer work, etc.)

_____

Most Recent Psychiatric Hospitalization:

Date	**Hospital**	**Primary Symptom**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legal/Issues:_____

History of Imprisonment:_____

Is consumer on probation:_____ **parole:**_____ **house-arrest:**_____

Parole/Probation Officer:_____ **Phone number:**_____

Has the referral ever been convicted of a felony? When and What was the charge(s)?

_____

Has the referral ever been convicted for a drug related crime (i.e. possession, selling, etc.)?

When and what was the charge(s)?_____

_____

Substance Abuse: Current:_____ **Past History:**_____

Substance(s) abused:_____

Are they currently receiving treatment for substance abuse and where:

_____

Physical Disability/Problem(s):

_____

****Date of last Physical:**_____ ****Physical/H&P attached:**_____

*****MUST BE SIGNED BY PHYSICIAN, not CRNP, PA, or RN!!!**

Psychological Testing Available: Y____N ____

Date of Testing: _____ By Whom?_____

(Attach copy of psychological to the referral)

Do you Have Diabetes? _____YES _____NO

Can you self-administer your Insulin _____YES _____NO

Would you like to receive Psychiatric care at Community Counseling Center ____YES ____NO

Other Providers Involved: (Psychiatrist, Therapist, PCP, BCM)

_____

_____

**** Current Medications (Attach a separate sheet if necessary):**

Name	Dosage	Frequency	Doctor

Problem List:

Diagnosis including /ICD 10 Code:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

GAF (DLA) _____

*****Referrals will not be accepted without the complete Diagnosis /ICD 10 Code and Psychiatrist/Doctor Signature*****

Psychiatrist/Doctor Printed Name:________________________

Psychiatrist/Doctor Signature:___________________________Date:_____________

License Number:_____________________ Expiration Date:____________________

History of Fire Setting/Arson? Y __________ N_________

History of Sexual Offenses? Y__________ N_________

History of Suicide Attempts Y _________ N ________

History of Physical Aggression? Y _________ N ________

Towards Others:________________________Towards Self:___________________

If Yes Additional Information Related:____

____

____

I understand that the information provided is true and correct to the best of my knowledge.

I acknowledge that my signature gives permission for the CCC staff to discuss my case with the agency/staff person submitting this referral.

Consumer Signature:___________________________________Date:___________________

Referral Signature:____________________________________Date:___________________

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FOR OFFICE USE ONLY

Actions taken: