Referral Guidelines

1. Participant must be 18 years or older, must reside in Allegheny County, and must be a HealthChoices member.
2. The individual must have a written recommendation for Psychiatric Rehabilitation Services from a **Licensed Practitioner of the Healing Arts (MD, DO, CRNP, PA, LCSW, LPC, LMFT, or Psychologist)**.
3. The individual must have a presence or history of a serious mental illness based on medical documentation which includes one of the following: **Schizophrenia; Major mood disorder; Psychotic disorder (not otherwise specified); Schizoaffective disorder; or Borderline Personality disorder.**
4. The individual must have moderate to severe functional impairment that interferes with at least one of the following domains: **Living, Learning, Working, Socializing, or Wellness. These impairments must be caused by the presence of the mental illness.**
5. The individual **must choose to receive Psychiatric Rehabilitation Services**.
6. **Exception**: Individuals who do met meet the serious mental illness diagnosis may receive services if the following conditions are met:
    a. Written recommendation by a LPHA includes a diagnosis of mental illness listed in the current DSM or ICD,
    b. Includes a description of the functional impairment resulting from the mental illness.
7. Please fully complete this referral form and return to

Joel Heiney, Intake & Resource Coordinator
Peoples Oakland
3433 Bates Street
Pittsburgh, PA 15213
Phone: 412.683.7140 x236 Fax: 412.683.7138
Email: joelh@peoplesoakland.org

Contact Info

Today's Date:

Consumer Name: _____ Address: _____

Birth Name/Other Names: _____ _____

Phone #: _____

Client ID# (**Intake use only**): _____ Social Security #: _____ - _____ - _____ Date of Birth: _____

Referral Source Information

Agency: _____

Contact: _____ Work Phone: _____ Email: _____

Treatment Team Information

Please identify members of this consumer's treatment team:

	Name	Agency	Phone
Psychiatrist:			
Therapist:			
Clinician:			
Service Coord:			
Other:			

Insurance Information

Medical Assistance ID#_____

Medical Assistance Provider:_____

Medicare ID# _____

Medicare Provider: _____

Private Insurance ID#_____

Private Insurance Provider:_____

Mental Health History

List Psychiatric hospitalizations over the last three years, starting with the most recent:

Hospital	From	To
_____	_____	_____
_____	_____	_____

Medical/Physical Health History

What physical health problems, if any, does this consumer have, and do they require special accommodation?

_____

_____

Medications

What, if any, are this consumer's current prescription medications? You may also attach an updated list of medications.

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is this consumer compliant with his/her current prescription medications? Yes _____ No _____

If not, please describe: _____

Substance Abuse

Date of onset of abuse problem: _____

Please list known substances of choice:

_____

If this consumer is not currently abusing substances, please indicate date of last known use: _____

Is this consumer actively involved in AA? _____ NA?

Comments regarding past D/A treatment or rehab: _____

_____

Housing

What is this consumer's current living arrangement?

____ Independent Living ____ Facility-Based 24-Hour Care ____ Criminal Detention

____Supervised or Supported Living ____ No Permanent Home/Homeless ____ Other

If not independent living, please provide the following information:

Facility Name:

Staff Contact:

Phone Number:

Behavioral

Does this consumer have a history of any of the following behaviors? If so, provide year of last incidence.

_____ Suicide Attempt (Year) _____ Sexual Abuse/Assault (Year) _____ Compulsive Behaviors [Lying, spending, etc.] (Year)

_____ Homicide Attempt (Year) _____ Assault (Year) _____ Drug/Alcohol Abuse (Year)

_____ Fire Setting (Year) _____ Theft (Year) _____ Other (Year)

Please provide details on treatment and/or legal outcomes subsequent to any of the above behaviors:

_____

_____

_____

If this consumer is on probation or parole, please provide information:

	Name of Officer	Probation/Parole Agency	Phone
Probation:	_____	_____	_____
Parole:	_____	_____	_____

If this consumer is currently facing legal charges, please describe:

_____

_____

Impairment/Needs Assessment

For each area, please rate on a scale of 0 to 5 the level of assistance the applicant needs or desires. Please identify the change that the applicant wishes to make in that domain, if any.

0 – Needs no assistance 1 – Needs minimal assistance 2 – Needs some assistance 3 – Needs moderate assistance 4 – Needs substantial assistance 5 – Needs extensive assistance

**Please note Psychiatric Rehabilitation regulations state that because of mental illness, the individual is considered to have a moderate to severe functional impairment that interferes with or limits performance in at least one of the following domains:

Domain	Scale Rating	Describe Impairment
Living		
Learning		
Working		
Socializing		

Referred By

Name:_____

Signature:_____ Date:_____

Applicant's Signature

My signature indicates that this referral has been discussed with me and I agree with it.

Applicant's Signature:_____ Date: _____

Recommendation for Psychiatric Rehabilitation Services

(The referral cannot be considered without this signed recommendation.)

DATE:_____

TO: Intake Coordinator, Peoples Oakland, Inc.

FROM:_____

RE: Recommendation for Referral to Peoples Oakland PRS

This memo serves as my formal recommendation for _____
Print applicant name
to receive Psychiatric Rehabilitation services at Peoples Oakland.

Clinical Information (mental, personality, and developmental disorders)	**ICD 10 Code**

Please attach most recent psych eval or other supporting medical record which includes the above diagnostic information.

_____ _____
Printed Name (*Include MD, DO, CRNP, PA, LCSW, LPC, LMFT, or Psychologist Designation)

NPI Number

_____ _____
Signature

Date

PLEASE NOTE In accordance with Pennsylvania guidelines and regulations for Psychiatric Rehabilitation, this recommendation MUST be signed by a "physician or licensed practitioner of the healing arts (LPHA) acting within the scope of professional practice."

Persons considered to be LPHA include only the following: Physicians (MD or DO), Certified Registered Nurse Practitioners (CRNP), Physician Assistants (PA), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC) or Psychologists (PhD or PsyD.