



Peer Support Services Referral Form

Name: _____

Date Referred: _____

Date of Birth: _____

Case #: _____

Social Security Number: _____

VBH-PA: YES _____ NO _____

County: _____ GAF: _____

Diagnosis _____

Address _____

Phone No.: Home () _____ - _____; Cell () _____ - _____; Work () _____ - _____;

Admission Criteria:

The following referral is an individual of 18 years of age or older and has a diagnosis of schizophrenia, major mood disorder, psychotic disorder NOS or borderline personality disorder, and meets at least one of the following criteria within the last TWO years: **(CHECK ALL THAT APPLY)**

___ Current residence in or discharge from a state mental hospital

___ Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days

___ Five or more face-to-face contacts with walk-in or mobile crisis or emergency services

___ One or more years of continuous attendance in a community mental health or prison psychiatric service

___ History of sporadic course of treatment as evidenced by at least three missed appointments with in the past six months, inability or unwillingness to maintain medication regimen, or involuntary commitment to outpatient services

___ One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician within the past two years

___ Global Assessment of Functioning Scale rating of 50 or below

___ or the peer is experiencing a coexisting Condition of Circumstances which may include one or several of the following:

___ Psychoactive Substance Abuse Disorder

___ Mental Retardation

___ Sensory, Developmental or Physical Disability

___ Homelessness

___ Release from criminal detention

___ HIV/AIDS

___ Involuntary Treatment

___ Adults who meet the standards for involuntary treatment within the past 12 months

Referring Agent:

Healing Arts Professional Signature:

Name: _____
(MD, DO, Psychiatrist, Psychologist, CRNP, PA)

Agency: _____
(Print Name)

Referring Agents contact information:

Office Telephone Number: _____ Email Address: _____

Address: _____

Peer Supervisor _____ Date Received _____ Date Contacted _____

Referral Accepted: _____ Services Started: _____

Referral Not Accepted: _____

Letter sent to referral source: _____