



**WEB REFERRAL FORM**  
**YOUNG ADULT COMMUNITY TREATMENT TEAM**  
250 EAST FAYETTE STREET  
UNIONTOWN, PA 15401  
724-437-1151  
FAX (724) 437-4915

**NAME:** \_\_\_\_\_ **BSU #:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **SSN #:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_  
\_\_\_\_\_  
**DATE OF REFERRAL:** \_\_\_\_\_

**CONTACT PERSON/RELATIONSHIP:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**PERSON/AGENCY MAKING REFERRAL:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**CONSUMER'S CASE MANAGER:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**CONSUMER'S CURRENT TREATING PHYSICIAN:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**CONSUMER'S THERAPIST:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**CONSUMER'S CURRENT PCP:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**REASON FOR REFERRAL/EXPECTED OUTCOME:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DIAGNOSES:**  
**AXIS I:** \_\_\_\_\_  
**AXIS II:** \_\_\_\_\_  
**AXIS III:** \_\_\_\_\_  
**AXIS IV:** \_\_\_\_\_  
**AXIS V: CURRENT GAF IS APPROXIMATELY** \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACTIVE MEDICAL PROBLEMS:**  
\_\_\_\_\_  
\_\_\_\_\_

**DRUG & ALCOHOL ISSUES:** \_\_\_\_\_

**LEGAL ISSUES:** \_\_\_\_\_

**AVAILABLE SUPPORT SYSTEM/FAMILY:** \_\_\_\_\_

**OTHER AGENCY INVOLVEMENT:** \_\_\_\_\_

- This individual is interested in and willing to receive CTT services at this time.
- This individual is between the ages of 18 and 30 years.
- This individual has serious mental illness *and* cognitive/developmental disability.
- This individual has had multiple psychiatric hospital or ED visits.
- This individual has substance abuse issues.
- This individual engages in high-risk behaviors.
- This individual is homeless or at risk for being homeless.
- This individual resides in a supervised community residence but could live more independently if intensive services were available.
- This individual is unable to successfully participate in traditional office-based provision of services.
- This individual lives within Fayette County.
- This individual is eligible for HealthChoices.

**SERVICE NEEDS (check all that apply):**

- Basic self-care/ADLs
- Symptom/illness management
- Housing/maintenance of household
- Substance abuse management
- Educational support
- Vocational support
- Financial management
- Legal support
- Family education
- Social/interpersonal skills/recreational support

**I agree to a referral for YACTT services.**

**SIGNATURE OF CLIENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Admission Committee Review Date:** \_\_\_\_\_

- Accepted
- Not Accepted because \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_