PEER SUPPORT – Referral Form
CHESTNUT RIDGE COUNSELING SERVICES, INC.

Client Name _____ **Age** _____ **DOB** _____

Address Street _____

City _____ **State** ____ **County** _____ *(Only Fayette County Residents Eligible)*

Home Phone _____ **Cell Phone** _____ **Alternate Phone** _____

Primary DSM Diagnosis & Code:

_____

Plus Functional Deficit Area(s) Checked Below

☐ **Yes** **If age 18 and above and Diagnosis is not** Schizophrenia, Major mood disorder, Psychotic disorder, Schizoaffective disorder, Borderline personality disorder should an exception be granted due below functional impairment related to the mental health diagnosis necessitating Psychiatric Rehabilitation Services?

☐ **Yes** **If age 14-18** with social, emotional behavioral disorder and one or more functional impairments listed below)

Check 1 or More Below Functional Areas Needing Improvement

☐	**Living –** *(Independent Living Skills, Cooking, Cost effective Shopping, Money Management, Using public transportation, Linking to Resources and Community Services)*
☐	**Educational/Vocational/Work/Volunteering**
☐	**Social** *- (Develop & Use Positive personal and social supports, Development of healthy Relationships, development of natural supports, friendship development, development and linkage with leisure/recreation/hobbies, Communication Skills)*
☐	**Wellness/Self Maintenance** *– (Life coaching by an Individual who is further along the journey in their own MH Recovery, Complete/Update – Wellness Recovery Action Plan (WRAP), Complete MH Advanced Directive, Activities to Increase of Self-Worth, Write and Follow self-designed prevention & wellness process to get well, stay well and make their life the way they want it to be MH Illness education, coping skills, self-advocacy, healthy lifestyle, family relationships, hobbies, follow thru with preventive and ongoing physical health services, quality of life satisfaction exploration and improvement, elimination of barriers, turning weaknesses into strengths.)*

If applicable, any additional Pertinent Information

Client Name _____

I am Recommending/Ordering Peer Support Services based on the individual's Mental Health Diagnosis and the above listed functional improvements needs.

_____ _____

Signature of Ordering/Referring Licensed Practitioner of the Health Arts **Date**

☐ **MD** ☐ **DO** ☐ **CRNP** ☐ **PA**

_____

Printed Name of Licensed Practitioner of the Health Arts

NPI # _____ **PA Promise ID** _____

If available, Alternate Contact for Referring Practitioner/Organization

Alternate Staff Name _____

Name of Practice/Organization _____

Direct Phone / Ext _____

If Known:

Type of Insurance(s):

☐ Beacon Health Options Medicaid ☐ Commercial Ins

☐ Medicare ☐ Non-managed Medicaid

☐ Commercially Managed Medicare ☐ No Current Insurance Coverage

Name of Client's Primary Insurance _____

Insurance ID # _____

Name of Client's Secondary Insurance _____

Insurance ID # _____

Fax Completed & Signed Form To:
CRCSI – Peer Support at (724) 437-3221

Any ? Call (724) 437-0729 Ext 657

Clients are eligible to continue in Outpatient and Community Based Services when while enrolled in Peer Support Services.