Chestnut Ridge Counseling Services, Inc
Peer Support Referral

Name:_____ Credible ID: _____

Address:_____

Type of Residence:___Independent___House/Apt___Supported___PCH___Other:_____

Phone:_____ County:_____ Social Security #:_____
VBH:_____ Education:_____ Employment Status:_____

Marital Status:_____ Age:_____ Gender: _____ DOB:_____ Ethnicity:_____

Diagnosis / Problem: 1. _____

2._____

3._____

Specify Areas of Impairment Affected for Justification of Services / Diagnosis Exception:

Living:
_____Financial Management
_____Housing / Household Maintenance

Education:
_____Educational Supports

Work:
_____Vocational Supports

Social:
_____Exploration of Interpersonal Leisure / recreation
_____Communication skills

Wellness / Self Maintenance:
_____Peer / Family Education and Support
_____Symptom / Illness Management
_____Basic Self- Care Skills, Activities of Daily Living

My signature on this form indicates my belief that this individual will benefit from his / her involvement with Peer Support services.

_____ _____
Healing Arts Professional Signature Date
(MD, DO, Psychiatrist, Psychologist, CRNP, PA)

_____ _____
Printed Name Credentials

NPI: _____ MA Promise ID: _____

Name:_____ **Credible ID:**_____

Current Treatment / Agency:_____

Doctor:_____ **Therapist:**_____

BCM:_____ **Agency:**_____

Other Supports:_____

History of Hospitalizations:_____

Medications:_____

_____

Limitations or Challenges:_____

Criminal History:_____

Drug / Alcohol Involvement:_____

Specific Reason for Referral:_____

_____

_____

I am interested in participating in Peer Support Services through CRCSI at this time:

_____ _____

Signature **Date**

Referring Agent:

Name:_____ **Date:** _____

Agency:_____ **Phone:**_____ **Email:**_____

Name:_____ **Credible ID:**_____

Received by:_____ **Date:**_____
Peer Support Supervisor

Referral Eligible: _____Yes _____No **Date:**_____

CPS Assigned:_____ **Date:**_____

If not accepted, date referring agency notified:_____