CHESTNUT RIDGE
COUNSELING SERVICES, INC

ACT WEB REFERRAL FORM

250 East Fayette Street
Uniontown, PA 15401
Fax: (724) 437-3221

Name: _____

DOB: _____ **Age:** _____ **SSN:** _____ **Gender:** _____

Address: _____

Phone #: _____ **Ethnic Origin:** _____ **Marital Status:** _____

Education: _____ **Occupation:** _____ **Income:** _____

Insurance: _____ **Insurance ID:** _____

Case Manager: _____

Reason for Referral:

_____
_____
_____
_____
_____
_____

****

Diagnosis:
Problem 1: _____
Problem 2: _____
Problem 3: _____
Problem 4: _____
Problem 5: _____

Current Medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Current Treatment:

Facility: _____

Doctor: _____ **Therapist/Social Worker:** _____

Significant Medical Conditions:

Substance Abuse Issues:

Legal Issues:

Family/Support Individuals:

Other Agency Involvement:

****

Referral Source: _____

Phone #: _____ **Date:** _____

Individual NPI #: _____ **PA Promise Medicaid #:** _____

Treatment/Social History (Check all that apply):

- ☐ **2 or more acute psychiatric hospitalizations within the past year**
- ☐ **30 days or more of a psychiatric hospitalization within the past year**
- ☐ **3 or more face-to-face crisis/emergency contacts within the past year**
- ☐ **Homeless, as defined by sleeping in shelters or places not meant for human habitation or at-risk for repeated evictions or loss of housing**
- ☐ **Placed on probation, parole or in a jail diversion program within the past 6 months or at-risk for involvement with the criminal justice system**
- ☐ **A co-existing substance abuse disorder of more than 6 months**
- ☐ **History of inability to participate in traditional office-based services despite documented efforts to engage the individual by a recognized mental health professional or case management provider, as evidenced by:**
  - ☐ **at least 3 missed mental health appointments within the past 6 months**
  - ☐ **documentation that the individual has not followed prescribed medication regime**
  - ☐ **history of court ordered treatment**
  - ☐ **documentation that the individual has not benefited from ICM services**

Functional/Service Needs (Check all that apply):

- ☐ **Basic self-care skills, activities of daily living**
- ☐ **Symptom/illness management**
- ☐ **Housing/household maintenance**
- ☐ **Social / interpersonal / leisure / recreational**
- ☐ **Family education and support**
- ☐ **Substance abuse management**
- ☐ **Educational / vocational support**
- ☐ **Financial management**
- ☐ **Legal support**
- ☐ **Other:** _____

****

The individual is interested in and chooses to receive ACT services at this time.

☐ **Yes** ☐ **No**

Signature: _____ **Date:** _____

****

Admission Committee Review Date: _____

Status:

☐ **Accepted**
Doctor's Signature: _____

☐ **Not Accepted**
Reason for Not Accepted:

_____
_____
_____
_____
_____