ACCESS SERVICES
unlocking potential

TIP Program Referral Form

(***Please attach the most recent psychiatric or psychological evaluation***)

Individual's Information:

Name: _____ Date of Referral:_____

SS#: _____ CMHC#: _____

MA#: _____

Private insurance: Y ◯ N ◯ Medicaid: Y ◉ N ◯

Date of Birth: _____ Age:_____ Gender: _____

Address: _____

County: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Type of Residence (own home, CRR, Recovery House, etc.): _____

Parent(s)/Guardian(s) Name: _____ Relationship: _____

Referral Source:

Name: _____ Organization: _____

Position: _____ Phone:_____

Email: _____ Address: _____

_____

Urgency of Referral: Urgent: ◯ Routine: ◉

Please describe primary reason for referral (What does the individual want to accomplish through TIP?)**:**

_____

_____

_____

_____

5 Axis Diagnosis: (F-Codes)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Individuals Name: _____

Current/Past Services Involved – Please list provider:

	Current	Past			Current	Past
Behavioral Health Rehabilitation Services: ☐ MT ☐ BSC ☐ TSS				Outpatient Therapy		
Partial Hospitalization				Residential/CRR		
Peer Support				D&A Treatment (Rehab, Detox, OP, IOP)		
Case Management: ☐ BCM ☐ D&A ICM ☐ ID SC				Probation/Juvenile Justice		
C&Y Involvement				Medical Doctor		
Medication Management/Psychiatrist				Family Based Services		
High Fidelity Family Teams				Educational Services		
Private Psychologist/Therapist				ACT/CTT		
MST				Other Supports (AA/NA, etc):		

Treatment History:

Contact with crisis services, crisis center, or ER for MH emergency within past 12 months?

_____

_____

Inpatient hospitalizations in past 12 months? Voluntary or involuntary? If yes, please include dates, length of stay, and location:

_____

_____

Significant medical issues or health concerns? If yes, is the individual receiving treatment?

_____

_____

Please list all current medications, dosages, and frequency:

_____

_____

Strengths and Supports:

Please describe the individual's strengths and interests:

_____

_____

Please describe the individual's support network and community involvement:

Referral Source Signature:_____ **Date:**_____

Individual's Signature:_____ **Date:**_____

Please attach the most recent psychiatric or psychological evaluation.

Submit this form to:

TIP@accessservices.org

Lehigh, Northampton & Bucks Counties
Mike McKenna / Erin Wilson
215-317-9939 / 484-934-8039
https://www.accessservices.org/services/tip/