Starting Point Referral

Please send referral and most recent psychiatric and medical evaluations to: spreferrals@accessservices.org

**if you do not have a recent psych/medical eval we will help you obtain one.*

For questions please call: 215-540-2150 ext. 1338

Date: ____________

INDIVIDUAL'S INFORMATION

Name: ________________________________ Gender: __________ Date of Birth: ________________

Address: ____

Phone: ____________________________ (Cell) ____________________________ (Home or Other)

Email: ____________________ Ethnicity: ____________________ Marital Status: _______________

SS#: _____________________ MHX#: ______________________ MA#: ______________________

REFERRAL SOURCE INFORMATION

Name of Referral Source: _____________________________ Organization: _____________________

Nature of Relationship to Person Referred: ____

Phone: ________________________________ Email: _____________________________________

Do you want to be a part of the initial meeting with person referred? ____________________________

PRIMARY REASON FOR REFERRAL (CHECK AS MANY AS APPLY)

- ○ Transitioning from a Residential Program to independent living
- ○ Diversion from a Residential Program
- ○ Intensive Care Coordination (Re-hospitalized w/in 30 days of previous hospitalization)
- ○ Transition-Aged Youth (Ages 18-26, aging out of the Children's System)
- ○ Other ____

PRIMARY NEEDS FOR SUPPORT AND SKILLS (CHECK AS MANY AS APPLY)

- ○ Living in the community (housing, managing daily life)
- ○ Wellness (Self-care, WRAP)
- ○ Learning (Going back to school, education about mental health)
- ○ Working (Finding or maintaining employment)
- ○ Socializing (Making friendships and meaningful connections in their community)
- ○ Other: ____

BENEFIT AND FINANCIAL INFORMATION

Income: <u>Source</u> <u>Amount</u>

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Total: ______________________________

Rep Payee: ______________________________ Phone Number: ______________________________

EMERGENCY CONTACTS AND OTHER SUPPORTS

<u>Emergency Contact:</u>

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

____

Phone: ______________________________

Email: ______________________________

<u>Family Member/Relative</u> *(if not listed as emergency contact)*

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

____

Phone: ______________________________

Email: ______________________________

<u>Substitute Decision Maker</u> *(someone who can make medical decisions for the individual in the event they are unable to)*

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

____

Phone: ______________________________

Email: ______________________________

<u>Recovery Coach/Blended Case Manager</u>

*For Montgomery County only Starting Point and RC services can not overlap for more than 30 days.

Name: ______________________________

Organization: ______________________________

Address: ______________________________

____

Phone: ______________________________

Email: ______________________________

<u>Therapist / Counselor</u>

Name: ______________________________

Organization: ______________________________

Address: ______________________________

____

Phone: ______________________________

Email: ______________________________

Date of last visit: ______________________________

<u>Psychiatrist</u>

Name: ______________________________

Organization: ______________________________

Address: ______________________________

____

Phone: ______________________________

Email: ______________________________

Date of last visit: ______________________________

HEALTH AND WELLNESS INFORMATION

Health Information

Date of last physical: _________________________

Physical health diagnoses/concerns:____

____

Mental health diagnoses: ____

____

Current medications, dosages, and frequencies (or attach medication list):____

____

Allergies____

____

Primary Care Physician

Practitioner's Name:______________________________

Name & Address of Practice: ______________________

____

____

Phone Number: _________________________________

Specialist

Practitioner's Name:_________________________

Type of Specialty: ___________________________

Name & Address of Practice: _________________

____

Phone Number: ____________________________

ADDITIONAL DETAILS

Highest Education Level Completed: ____

Employer/Employement Status:____

Is there a *traumatic history* that you want us to be aware of? ____

____

____

Has *substance abuse* been a struggle for you? ____

____

____

Do you currently or have you struggled in the past with *thoughts of suicide*? _________________________

____

____

Do you currently or have you in the past thought about or acted on *violent impulses*? _________________

____

____

____

Do you have any *legal issues* or involvement? ____

____

____

____

HOW CAN WE BE HELPFUL TO YOU?

Individual's goals and hopes for our support:____

Helpful approaches to support: ____

Unhelpful approaches to support: ____

ADDITIONAL COMMENTS:

Signature of Referral Source: ____

Signature of Person Being Referred: ____

Starting Point PRS LPHA Recommendation Form

Must be completed by a psychiatrist, doctor, certified registered nurse practitioner, psychologist, LMFT, LPC, or LCSW

Name of Person being referred: ____
Date of Birth: (at least 18 years or older)____

Admission Criteria:

Please indicate one of the following five qualifying diagnoses and ICD-10-CM Code:

___Schizophrenia
ICD-10-CM code: ____

___Major mood disorder
ICD-10-CM code: ____

___Psychotic disorder NOS
ICD-10-CM code: ____

___Schizoaffective disorder
ICD-10-CM code: ____

___Borderline personality disorder
ICD-10-CM code: ____

IF REQUESTING AN EXCEPTION:

1. Diagnosis and ICD-10-CM Code:

____

____

2. Please provide a brief statement outlining the functional impairment as a result of diagnosis:

____

____

____

As a result of mental illness, **there is the presence of a limitation in at least one of the following areas** (functional impairment), check all that apply:

___Educational (e.g. Obtaining a degree, taking classes)

___Social (e.g. Developing social support system, attending activities and groups in the community)

___Vocational (e.g. Obtaining and maintaining employment, resume writing, interviewing)

___Self-maintenance (e.g. Managing symptoms, managing money, living independently)

This referral and recommendation has been discussed with the person being referred and they are agreeing to participate.

____
Practitioner's Signature, Credentials and Date

____
PLEASE PRINT NAME