



Starting Point Referral Form

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: _____ Race: _____ 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 Support

Emergency Contact:

Name: _____
Relationship: _____
Address: _____

Phone: _____
Email: _____

Family Member/Relative *(if not listed as emergency contact):*

Name: _____
Relationship: _____
Address: _____

Phone: _____
Email: _____

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

Name: _____
Relationship: _____
Address: _____

Phone: _____
Email: _____

Recovery Coach/Blended Case Manager:

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

Name: _____
Organization: _____
Address: _____

Phone: _____
Email: _____

Therapist/Counselor:

Name: _____
Organization: _____
Address: _____

Phone: _____
Email: _____
Date of last visit: _____

Psychiatrist:

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/Employment 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 Mobile Psychiatric Rehabilitation Services 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 and Credentials

PLEASE PRINT NAME

DATE

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