BUCKS/MONTGOMERY COUNTY
PEER SUPPORT SERVICES
REFERRAL FORM

Peer Support Services involve a working partnership between the Peer Support participant and a person who is a former or current recipient of mental health and/or co-occurring substance use services. Using their shared life experience with mental illness, the participant and the Peer Support staff person work together to further the participant's wellness and meaningful daily living and community role development. This is accomplished through, but not limited to, recovery education, community resource coordination/linkage , daily living skill instruction, advocacy, and development of natural supports. Applicants May Self-Refer.

Include an updated psychiatric evaluation from within the past year..

SECTION I

Date of Referral: _____ **Provider #:**_____

Applicant Name: _____
(Last) *(First)* *(M.I.)*

Date of Birth: _____ **Social Security #:** _____

Address: (if homeless, last known address)

_____

_____

E-mail address (optional):_____

Home: _____ **Work #:**_____ **Cell #:**_____

Type of Insurance: (check all that apply)

- ☐ **Medical Assistance (Specify M.A. #)**_____
- ☐ **Medicare**

Reason for referral/How are you hoping to benefit from Peer Support Services ?

_____

_____

_____

Area in which you are interested in making a change (check all that apply):

_____Housing _____Employment _____School _____Personal wellness

_____Community Connection

Applicant Signature (required): _____

SECTION II **(Complete This Section If Referral Source Is Different Than Applicant)**

Referral Source Name: _____

Phone #: _____ **Fax #:** _____

E-mail address: _____

Additional comments: _____

_____

_____

_____

Referral Source Signature: _____

SECTION III

Support Summary

Type	Agency	Contact Person	Phone Number/Email
Psychiatrist			
Mental Health Therapist			
Substance Use Therapist			
Case Manager			
Intensive Psych Rehab Worker			
Clubhouse Worker			
Vocational Program Worker			
Housing Program Worker			
Probation/Parole Officer			
Family Member(s)			
Friend(s)			
Other			

Medical (include allergies) or Physical Needs

_____

_____

Current Medications: Include Name, Dosage

_____

_____

SECTION IV **(This section to be completed by staff)**

Primary dx:_____ DSM: _____

_____ DSM: _____

Secondary dx: _____ DSM: _____

_____ DSM: _____

Impact of psychiatric diagnoses on functioning (please check all that apply, circle the severity and comment):

Life Domains	Level of Impairment	Comment
□ Employment	None Mild Moderate Severe	_____
□ Education	None Mild Moderate Severe	_____
□ Independent Living	None Mild Moderate Severe	_____
□ Wellness Management	None Mild Moderate Severe	_____
□ Social Supports	None Mild Moderate Severe	_____

I recommend _____ to receive Peer Support Services.

applicant name

_____ _____

LPHA Signature *Date*

(Licensed Professional of the Healing Arts –MD/DO, Licensed Psychologist, Nurse Practitioner)