RHD Allies

Forensic Certified Peer Specialist Program

REFERRAL

DIRECTIONS: Please return this completed form, along with a **Psychiatric Evaluation signed by a psychiatrist or MD, to: RHD Allies, 810 River Avenue, Suite 250, Pittsburgh PA 15212. You may also FAX this form to (412) 652-9197.**

Date of referral: _____

Name: _____ Birth Date: _____ / _____ / _____

Address: _____ City, State, Zip _____

Home Phone: _____ Cell Phone: _____ SSN: _____

EMERGENCY CONTACT Family member, guardian, or significant other to be notified in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City, State, Zip: _____ Cell Phone: _____

A. HEALTH AND SOCIAL SERVICE INFORMATION

	Name	Location	Phone
Psychiatrist			
Therapist			
Service Coordination			
Medical Doctor			
JRS Caseworker			
Probation/Parole Officer			
Housing			
Other			

List any medical problems or physical disabilities, especially those that would limit physical activities or those that require assistive technology or an interpreter:

_____

Describe applicant's current involvement with criminal justice system: _____

_____

Involvement with Specialty Court? ☐ No ☐ Yes If yes, please specify: _____

B. SOURCE OF INCOME

☐ SSI ☐ SSDI ☐ VA ☐ Job ☐ Other: _____

Does the member have a representative payee? ☐ No ☐ Yes If yes, please specify: _____

C. HEALTH INSURANCE

Medical Assistance ID#: _____ Medical Assistance Provider: _____

D. CLINICAL HISTORY

1. INPATIENT HOSPITALIZATION HISTORY (Add additional pages if needed)

Facility/Address	From	To

Has the applicant ever exhibited or made threats of harm to self or others? If so, explain.

2. OUTPATIENT TREATMENT HISTORY (Add additional pages if needed)

Facility/Address	From	To

3. CURRENT MEDICATIONS (Add additional pages if needed)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

4. MEDICAL NECESSITY

MUST MEET ONE OF THE CATEGORIES A or B or C or D. ***Check box and attach supporting documentation***

A. Treatment History

- ☐ Currently resides in State Mental Hospital or discharged from State Mental Hospital in the past 2 years
- ☐ 2 admissions to inpatient psychiatric unit or crisis residential totaling 20 or more days in the past 2 years
- ☐ 5 or more face to face contacts with walk-in, mobile, or emergency services within the past 2 years
- ☐ 1 or more years of continuous attendance in a community mental health or prison psychiatric service within the past 2 years
- ☐ History of sporadic course of treatment, inability to maintain med regime or involuntary commitment to outpatient services
- ☐ 1 or more years of mental health treatment provided by a PCP within the past 2 years

B. Global Assessment of Functioning rating is 50 or below

- ☐ Yes

C. Coexisting Condition or Circumstance with Mental Illness

- ☐ Psychoactive substance use disorder
- ☐ Intellectual Developmental Disorder
- ☐ HIV/AIDS
- ☐ Sensory disability Specify:
- ☐ Developmental disability Specify:
- ☐ Physical disability Specify:
- ☐ Homelessness
- ☐ Release from criminal detention

D. Involuntary Treatment Status

- ☐ Met standards for involuntary treatment in the past 12 months preceding this assessment

E. FUNCTIONAL ASSESSMENT

For each area, please rate on a scale of 0 to 5 the level of assistance the applicant needs or desires. Please identify the change that the applicant wishes to make in that domain, if any. **Please note that regulations state that scores of "moderate assistance" (3) or above in at least one domain meet criteria for medical necessity for this service.**

0- Needs no assistance
1- Needs minimal assistance
2- Needs some assistance
3- Needs moderate assistance
4- Needs substantial assistance
5- Needs extensive assistance

Scale	Domain	Describe needs and goals in each domain
_____	Living/Self-Maintenance:	_____
_____	Learning:	_____
_____	Working:	_____
_____	Socializing:	_____

F. REFERRED BY (Please print):

Name: _____ Title: _____
Agency: _____ Phone: _____
Signature: _____ Email: _____

G. APPLICANT'S SIGNATURE:

My signature indicates that this referral has been discussed with me, and I am in agreement with it.

Applicant's Signature: _____ Date: _____

REFERRAL CHECKLIST – All applicants will need to provide the following items:

☐ Completed referral form (this form)	☐ Psychiatric evaluation signed by an MD or psychiatrist. Must be current within 2 years.
☐ Signed Release of Information form	☐ Signed recommendation from MD or psychiatrist (see page 4)

THIS SECTION IS TO BE COMPLETED BY PSYCHIATRIST, PHYSICIAN, CERTIFIED REGISTERED NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT.

TO: Unit Director, RHD Allies
FROM: _____
DATE: _____
RE: Recommendation for Referral to RHD Allies Forensic Certified Peer Specialist Services

This memo serves as my formal recommendation for _____
(print applicant's name)

to receive Certified Peer Specialist Services through RHD Allies.

MENTAL HEALTH DIAGNOSIS:

REASON FOR REFERRAL (How will this individual benefit from Peer Support Services?):

_____ _____
Signature Date

_____ _____
Printed Name Title

_____
NPI Number

Note: In accordance with Pennsylvania guidelines and regulations for Peer Support Services, this recommendation must be signed by a "physician or licensed practitioner of the healing arts (LPHA) acting within the scope of professional practice." **Persons who are considered to be an LPHA currently only include Medical Doctors (MD), Certified Registered Nurse Practitioners (CRNP), or Physician's Assistants (PA)**.

The referral cannot be considered to be complete without this signed recommendation.

Please contact the Unit Director for any questions regarding this referral form.

Referral approved by:

_____ _____
RHD Allies Unit Director Date

Applicant Name: _____