Referral for Mobile Services

Please Select Service(s) of Interest

☐ Certified Peer Support: Allies

☐ Mobile Psychiatric Rehabilitation: Allegheny Mobile Services

DIRECTIONS: Please return this completed form, along with a copy of most recent psychiatric evaluation via fax to **412-652-9197** or email mobileservices@rhd.org

Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ SSN: _____

Medical Assistance Provider: _____ Medical Assistance ID: _____

Birth Sex: ☐ Male ☐ Female **Gender:** _____

Race: ☐ White/Caucasian ☐ Black/African American ☐ Native American
☐ Asian ☐ Native Hawaiian/Pacific Islander

Ethnicity: ☐ Hispanic ☐ Not Hispanic

A. HEALTH AND SOCIAL SERVICE INFORMATION

	Name	Organization/Practice	Phone Number
Psychiatrist			
Therapist/Counselor			
Service Coordinator			
Primary Care Doctor			
Probation/Parole			
Housing Support Provider			
Other			
Other			

Does the applicant have any medical conditions, physical disabilities or support needs the program should be aware of to better support them (e.g. limits on physical activity, need for assistive technology, or interpreter services)? ☐ No ☐ Yes, briefly describe:

_____

Does the applicant have current involvement with the criminal justice system or specialty court?
☐ No ☐ Yes, briefly describe:

_____

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B. Primary Source of Income

☐ Employment	☐ SSI/SSDI
☐ Unemployment Benefits	☐ Retirement/Pension
☐ Family/Friend Support	☐ No Income

C. Treatment History

Outpatient Program Name	Admit Date	Discharge Date

D. Inpatient Treatment History

Inpatient Program Name	Admit Date	Discharge Date

E. Functional Assessment

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

0: No Assistance Needed | **1**: Needs Minimal Assistance | **2**: Needs Some Assistance | **3**: Needs Moderate Assistance | **4**: Needs Substantial Assistance | **5**: Needs Extensive Assistance

Rating	Domain	Identified Needs and/or Goals
_____	Living/ Self Maintenance	
_____	Learning	
_____	Working	
_____	Socializing	
_____	Wellness	

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Additional Information:

F. Referral Information/ Applicant Interest

To the best of my knowledge, the applicant is aware of this referral, has expressed interest in receiving support for behavioral health recovery, and agrees to be contacted regarding services.

Name:	**Title:**	**Email:**
Phone:	**Organization:**	

_____ _____
Referral Signature Date

_____ _____
Applicant Signature *(optional)* Date

G. Referral Checklist

Please ensure the following items are submitted with this referral form:

☐ Signed Release of Information
☐ Psychiatric Evaluation within the last 2 years (if available)
☐ Recommendation from a Licensed Practitioner of the Healing Arts (last page)

RESOURCES FOR HUMAN DEVELOPMENT

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This section is to be completed by a licensed practitioner of the healing arts (LPHA) (i.e. Physician, Psychiatrist, Psychologist, CRNP, PA, LPC, LMFT, LCSW).

This document serves as my formal recommendation for _____ to receive services through RHD.
(APPLICANT NAME)

Mental Health Diagnosis:

Purpose of Referral:

_____ _____
Signature Date

_____ _____
Printed Name and Title License Number