FORM INSTRUCTIONS

1. Only one service provider can be requested at a time.
2. All sections of this document must be thoroughly completed and legible in order to make a determination of services. Items should not be left blank-please indicate N/A where appropriate. Also, a current psychiatric or psychological evaluation completed within past 12 months, and a list of the most recent medications must be attached with the referral. Incomplete referrals will not be accepted.
3. The signature of the person being referred is required indicating that they understand that a referral is being made. If the person is unable to sign, the referral source must state if it is due to current symptoms, physical limitations, or other.
4. Fax the completed referrals to one of the providers listed below.

REFERRAL SOURCE RESPONSIBILITY

1. If Service Coordination Unit is unable to make contact with the referred individual, the referral source will be responsible for assisting the Service Coordination Unit in making contact with the referred individual.
2. If an individual is being referred by a hospital, the referral should be submitted as soon as it is recognized that they are in need of Service Coordination. This will permit the SC to meet with the service participant before they are discharged from the inpatient unit.

CHILD/ADOLESCENT SERVICE COORDINATION PROVIDERS IN ALLEGHENY COUNTY

Allegheny Children's Initiative (ACI)
412-431-8006 (Ph)
412-431-8124 (Fax)

Mon- Yough Community Services (MYCS)
412-675-6927 (Ph)
412-664-0109 (Adult Fax)
412-675-8484 (Child Fax)

Family Services of Western PA (FSWP)
724-230-2777 (Ph)
724-230-2778 (Fax)

Mercy Behavioral Health (MBH)
412-323-8026 (Ph)
412-320-2376 (Fax)

Milestone Centers
412-243-3400 (Ph)
412-244-4781 (Fax)

Western Psychiatric Institute and Clinic (WPIC)
412-204-9001 (Ph)
412-204-9134 (Fax)

Human Services Administration Organization (HSAO)
412-884-4500 (Ph)
412-885-3900 (Fax

Pressley Ridge
412-442-2080 (Ph)
412-321-0508 (Fax)

Chartiers Center
412-221-3302 (Ph)
412-257-2008 (Fax)

Turtle Creek Valley MH/MR (TCV)
412-351-0222 (Ph)
412-351-0695 (Fax)

REFERRAL DATE:	SERVICE PARTICIPANT NAME:

Section A. Eligibility Criteria

I. Diagnosis: Any child/adolescent up to the age of 18 (or to 21 if the child/adolescent has an Individualized Education Plan or is moving to the adult system) who has a diagnosis of Schizophrenia or Mood Disorder or any Axis I diagnosis in the DSM excluding Intellectual Disability or Psychoactive Substance Use or Organic Brain Syndrome or V Code

II. Treatment History: Must have one (1) of the following:

☐	At risk for out-of-home placement without services.
☐	Returning from community inpatient or other out-of home placement.
☐	Age 6 years or younger and require or enrolled in Early Intervention Services.
☐	Receiving with their family, services from 2 or more publicly funded programs.
☐	Recommended as needing MH Services by local county interagency team.
☐	Transfer from another Blended Services Coordination Provider. Anticipated closure date:

Reason for referral-please indicate how service Participant could benefit from Service Coordination. Please be specific.

Service Participant Name:

Name of agency where referral is being made… Only one agency is to be selected

☐ Chartiers	☐ Milestone	☐ HSAO
☐ FSWP	☐ MYCS	☐ Pressley Ridge
☐ MBH	☐ Staunton	☐ ACI
☐ WPIC		☐ TCV

Section B. Referral Source Information

Referral Source Title:			
Referral Source name:			
Agency Name:			
Phone#:		Cell #	Fax#
Email:			

Section C. Service Participant Demographics

Participant Name	Last		First	
Participant Alias Name	Last		First	
Date of Birth		Age	SS#	Gender
Ethnicity		Primary Language:		
Grade in school		Name of School:		
Special Education	☐Yes ☐No	What Level:		
Current Address	☐ *check here if Homeless*			Zip Code:
Email Address				
Accommodations	☐TTY ☐ Interpreter ☐ Sign language ☐ Ambulatory limitations ☐ Other			
Parent	Last Name:		First Name:	
Parent Phone	Home:		Cell:	
Parent Email Address				
Guardian	Last		First	
Guardian Type	☐Medical/Educational Guardian ☐ Guardian ad litem ☐Permanent legal custodian			
Guardian Phone	Home:		Cell:	
Guardian Email Address				

Service Participant Name:

Section D. Health Insurance Information

Medical Assistance ☐ Yes ☐ No	ID #	Other:

Section E. Other Agency/Program Involvement

Independent Supports Coordinator		Phone:
Service Coordinator		Phone:
Community Treatment Team		Phone:
Certified Peer Specialist		Phone:
CYF Case Worker		Phone:
Probation Officer		Phone:
Housing Provider		Phone:
School Contact Person		Phone:
Has a referral been made to any housing programs ☐Yes ☐No If yes, date referral was made: Explanation:		

Section F. Mental Health Information *(DSM Diagnosis- Please attach a recent psychiatric evaluation or Doctor's signature to verify diagnosis completed within past 12 months).*

Please include a primary behavioral health diagnosis. Other diagnoses may be included		
Behavioral Health		
Behavioral Health		
Medical Conditions		
Medical Conditions		
Last Psychiatric Eval		Completed by:

Section G. Current Outpatient Provider/Services/Supports

CURRENT PROVIDER	**PROVIDER AGENCY**	**CONTACT NAME**	**CONTACT PHONE NUMBER**
Outpatient Psychiatrist			
Outpatient Therapist			
Primary Care Physician			
Medical Specialist			
BHRS			
Family Based- Family Focus			
Residential Treatment Facility			

Service Participant Name:

Section H. Risk Factors *(Additional sheets can be attached if needed)*	Yes	No	Time Frame
Suicidal ideation/attempt? Explain:	☐	☐	
Self- injurious behaviors? Explain:	☐	☐	
Physical Harm to Others? Explain:	☐	☐	
Victimization of Others? Explain:	☐	☐	
Destruction of Property? Explain:	☐	☐	
Fire Setting? Explain:	☐	☐	
Sexually Abusive/Inappropriate to Others? Explain:	☐	☐	
Probation? Explain:	☐	☐	
Sexual Acting Out (specify as abusive or sexually reactive behaviors) Explain:	☐	☐	
Risk of Eviction or homelessness? Explain:	☐	☐	
Access to weapons in the home or elsewhere? Explain:	☐	☐	
Major Medical concerns? Explain:	☐	☐	
Pets in the home? Explain:	☐	☐	
School Problems Explain:	☐	☐	
Family Concerns Explain:	☐	☐	
Other: Explain:	☐	☐	

Service Participant Name:

Section I. AUTHORIZATION FORM

I agree to this referral and authorization. In an event I cannot be reached or additional information is needed, I authorize other service providers or organizations listed on this referral be contacted on my behalf for the purpose of coordinating this referral.

Print Name _____ Date _____

Service Participant Signature (14 or older) _____

Print Name _____ Date _____

Parent or Guardian Signature _____

Print Name _____ Date _____

Referral Source Signature _____

Is Service Participant agreeable to services? ☐ Yes ☐ No
If No, explain: