Allegheny County Department of Human Services
Office of Behavioral Health
Adult Service Coordination Referral Form

REFERRAL DATE:	SERVICE PARTICIPANT NAME:

FORM INSTRUCTIONS

1. Only **ONE** service provider can be requested at a time.
2. Please be specific when describing the need for Service Coordination.
3. All sections of this document must be completed thoroughly and typed in order to make a determination of services.
4. Items should not be left blank-please indicate N/A where appropriate.
5. Incomplete referrals will not be accepted.
6. A verification of psychiatric diagnosis (completed by MD), and a list of the most recent medications must be attached with the referral.
7. The signature of the person being referred indicating that they understand that a referral is being made. **** If the person is unable to sign, the referral source must provide information and why it was not obtained – this could include verbal agreement.**
8. Email is preferred, unless delineated by specific provider.

REFERRAL SOURCE RESPONSIBILITY

1. If Service Coordination Unit is unable to contact the referred individual, the referral source will be responsible for assisting the Service Coordination Unit in contacting 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.

NAME OF PROVIDER REFERRAL IS BEING MADE (**ONLY ONE** may be selected):

☐ Chartiers ☐ WFS ☐ Pgh Mercy ☐ Milestone ☐ MYCS ☐ Staunton ☐ TCV ☐ WPH

ADULT SERVICE COORDINATION PROVIDERS IN ALLEGHENY COUNTY

Chartiers Center
412-221-3302 (Ph)
412-257-2008 (**Fax- preferred**)
Jrosenberger@chartierscenter.org

Pittsburgh Mercy
412-323-8026 (Ph)
412-320-2376 (Fax)
SCREFERRALS@PittsburghMercy.org

Milestone Centers
412-243-3400 (Ph)
412-244-4781 (Fax)
mcampbell@milestonepa.org

Wesley Family Services
724-895-8262 (Ph)
724-230-2778 (Fax)
Kimberly.Romito@wfspa.org

ADULT SERVICE COORDINATION PROVIDERS IN ALLEGHENY COUNTY (cont'd)

Staunton Clinic
412-749-7330 (Ph)
412-749-7765 **(Fax- preferred**)
rkyle@hvhs.org

UPMC Western Behavioral at Mon Yough (MYCS)
412-675-8480 (Ph)
412-664-0109 (Fax)
MYCSFAXADULTSC@UPMC.edu

Turtle Creek Valley (TCV)
412-351-0222 (Ph)
412-351-0695 (Fax)
BSCReferrals@tcv.net

Western Psychiatric Hospital (WPH)
412-204-9001 (Ph)
412-204-9134 (Fax)
BSCreferrals@upmc.edu

Section A. ELIGIBILITY CRITERIA

I. Persons eligible for Adult Service Coordination are 18 years of age or older, who have a Diagnosis within the **DSM IV R (or succeeding revisions thereafter) completed by a Doctor**, excluding those with a principal diagnosis of Intellectual Disability (formerly mental retardation), psychoactive substance use, organic brain syndrome or V-Code.

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

☐	Six or more days of inpatient treatment within the past twelve months
☐	Met standards for involuntary treatment within the past twelve months
☐	Two or more face to face contacts with emergency personnel within the past twelve months (i.e. after hours, Crisis Services, ER visits, Police)
☐	Missed at least three or more community mental health service appointments (within what time period), or documentation that the consumer has not maintained medication regimen for a period of at least 30 days.
☐	Transfer from another Service Coordination Provider Current Service Provider:
☐	Currently receiving or in need of MH services or in need of services from two or more human services agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc. Anticipated closure date:

Reason for referral: *Indicate **SPECIFIC REASON** how service Participant could benefit from Service Coordination, keeping in mind a need for transportation is NOT a reason for referral*

Section B. Referral Source Information

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

Section C. Service Participant Demographics

Name:	Last		First	
Preferred Name:	Last First		Preferred Pronouns:	
Date of Birth:		Age	SS#	Gender
Ethnicity:		Primary Language:		Race:
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Partnered			
Veteran:	☐ Yes ☐ No	If yes, year of discharge?		Branch:
Current Address:	Address:			Phone:
Homeless:	☐ YES ☐ NO	If Facility Name:		Phone:
Contact Numbers	Home:	Cell:		Best time to call:
Email Address:				
Accommodations:	☐ TTY ☐ Interpreter ☐ Sign language ☐ Ambulatory limitations ☐ Other			

Section D. Health Insurance Information

Medical Assistance: ☐ Yes ☐ No	Medicare: ☐ Yes ☐ No	Other:	Medical Assistance or ID #:

Section E. Emergency Contact Information

Name:	Relationship:
Address:	
Phone Number:	
Guardian Name if applicable:	Phone:

Section F. Health and Wellness

Known Allergies:

Section G. Other Agency/Program Involvement LIST ALL ACTIVE SERVICES:				
Program Support: ***(choose from drop-down menu)***	Agency:	Name of primary provider contact:	Phone:	Email:
Choose an item.				
Choose an item.				
☐CHIPP ☐ACSP ☐CSP/CIT	If Applicable to CSP/ACSP please attach plan			
Has the individual previously received SC Services? ☐ Yes ☐ No If yes, previous provider:				
Has a referral been made to any housing programs ☐Yes ☐No If yes, date referral was made: Explanation/Type of Housing:				

Section H. Mental Health Information ***(DSM Diagnosis- Please attach a verification of psychiatric diagnosis with MD's signature).***			
Please include a primary behavioral health diagnosis. Other diagnoses may be included			
Behavioral Health:		Code:	
Medical Conditions:			
Last Psychiatric Eval:		Completed by:	

CURRENT PROVIDER	**PROVIDER AGENCY**	**CONTACT NAME**	**CONTACT PHONE NUMBER**
Outpatient			
Primary Care			

Section I. Risk Factors *(Additional sheets can be attached if needed)*	Yes	No	Time Frame
Suicidal ideation/attempt and/or Self Injurious Behaviors? Explain:	☐	☐	
Physical Harm to Others or Destruction of Property? Explain:	☐	☐	
Victimization of Others? Explain:	☐	☐	
Fire Setting? Explain:	☐	☐	

Sexually Inappropriate or Offensive Behaviors? Megan's Law Registry? Explain: Explain:	☐	☐	
Risk of Eviction or homelessness? Explain:	☐	☐	
Access to weapons in the home or elsewhere? Pets in the Home? Explain: Explain:	☐	☐	
Major Medical concerns? Explain:	☐	☐	

Section J. Legal History *(attach additional sheets if needed)*

CRIMINAL CHARGES CURRENT/ PAST 5 YEARS *(choose from drop-down menu)*	**ARREST DATE (IF APPLICABLE)**	**OUTCOME OF ARREST (IF APPLICABLE)**	**RELEASE DATE (IF APPLICABLE)**	**CONVICTED**	**CONVICTION/ DISPOSITION (IF APPLICABLE) *(choose from drop-down menu)***
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
If OTHER Charge Identified Explain:					
Probation or Parole Involved? ☐ **YES** ☐ **NO** **If Yes, Level:** ☐ **County** ☐ **State** ☐ **Federal** P.O. Name: Phone: Email:					

Section K. AUTHORIZATION

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.

Service Recipient Signature: _____ Date

Referral Source Signature: _____ Date:

Is Service Participant agreeable to services? ☐Yes ☐No Explain: