Starting Point Referral Form

Please send referral and most recent psychiatric and medical evaluations to: spreferrals@accessservices.org

*if you do not have a recent psych/medical eval we will help you obtain one. For questions please call: 215-540-2150 ext. 1338

Date: _____

Individiual's Information

Name: _____ Gender: _____ Date of Birth: _____

Address: _____

Phone: _____ (Cell): _____ (Home or Other)

Email: _____ Ethnicity: _____ Race: _____ Marital Status: _____

SS#: _____ MHX#: _____ MA#: _____

Referral Source Information

Name of Referral Source: _____ Organization: _____

Nature of Relationship to Person Referred: _____

Phone: _____ Email: _____

Do you want to be a part of the initial meeting with person referred? _____

Primary Reason for Referral (Check as many as apply)

- ◯ Transitioning from a Residential Program to independent living
- ◯ Diversion from a Residential Program
- ◯ Intensive Care Coordination (Re-hospitalized w/in 30 days of previous hospitalization)
- ◯ Transition-Aged Youth (Ages 18-26, aging out of the Children's System)
- ◯ Other _____

Primary Needs for Support and Skills (Check as many as apply)

- ◯ Living in the community (housing, managing daily life)
- ◯ Wellness (Self-care, WRAP)
- ◯ Learning (Going back to school, education about mental health)
- ◯ Working (Finding or maintaining employment)
- ◯ Socializing (Making friendships and meaningful connections in their community)
- ◯ Other: _____

Benefit and Financial Information

Income: Source Amount

_____ _____

_____ _____

_____ _____

Total: _____

Rep Payee: _____ Phone Number: _____

Emergency Contacts and Other Support

Emergency Contact:

Name:_____

Relationship:_____

Address:_____

_____

Phone:_____

Email:_____

Family Member/Relative (*if not listed as emergency contact*):

Name:_____

Relationship:_____

Address:_____

_____

Phone:_____

Email:_____

Substitute Decision Maker *(someone who can make medical decisions for the individual in the event they are unable to)*:

Name:_____

Relationship:_____

Address:_____

_____

Phone:_____

Email:_____

Recovery Coach/Blended Case Manager:

*For Montgomery County Starting Point only and RC services cannot overlap for more than 30 days.

Name:_____

Organization:_____

Address:_____

_____

Phone:_____

Email:_____

Therapist/Counselor:

Name:_____

Organization:_____

Address:_____

_____

Phone:_____

Email:_____

Date of last visit:_____

Psychiatrist:

Name:_____

Organization:_____

Address:_____

_____

Phone:_____

Email:_____

Date of last visit:_____

Health and Wellness Information

Health Information

Date of last physical: _____

Physical health diagnoses/concerns:

_____

Mental health diagnoses:

_____

Current medications, dosages, and frequencies (or attach medication list):

_____

_____

Allergies

_____

Primary Care Physician:

Practitioner's Name: _____

Name & Address of Practice:

_____

_____

Phone Number: _____

Specialist:

Practitioner's Name: _____

Type of Specialty: _____

Name & Address of Practice:

_____

Phone Number: _____

Additional Details

Highest Education Level Completed: _____

Employer/Employment Status: _____

Is there a *traumatic history* that you want us to be aware of?

_____

_____

Has *substance abuse* been a struggle for you?

_____

_____

Do you currently or have you struggled in the past with *thoughts of suicide*?

_____

_____

Do you currently or have you in the past thought about or acted on *violent impulses*?

_____

_____

_____

Do you have any *legal issues* or involvement?

_____

_____

_____

How Can We Be Helpful to You?

Individual's goals and hopes for our support:

Helpful approaches to support:

Unhelpful approaches to support:

Additional Comments:

Signature of Referral Source: _____

Signature of Person Being Referred: _____

Starting Point Mobile Psychiatric Rehabilitation Services LPHA Recommendation Form

Must be completed by a psychiatrist, doctor, certified registered nurse practitioner, psychologist, LMFT, LPC, or LCSW

Name of Person being referred: _____
Date of Birth: (at least 18 years or older) _____

Admission Criteria:

Please indicate one of the following five qualifying diagnoses and ICD-10-CM Code:

☐ Schizophrenia
ICD-10-CM code:____

☐ Major mood disorder
ICD-10-CM code: ____

☐ Psychotic disorder NOS
ICD-10-CM code:____

☐ Schizoaffective disorder
ICD-10-CM code:____

☐ Borderline personality disorder
ICD-10-CM code:____

☐ Post Traumatic Stress Disorder
ICD-10-CM code:____

☐ Anxiety disorder
ICD-10-CM code:____

If Requesting an Exception:

1. Diagnosis and ICD-10-CM Code:

_____

_____

2. Please provide a brief statement outlining the functional impairment as a result of diagnosis:

_____

_____

_____

As a result of mental illness, **there is the presence of a limitation in at least one of the following areas** (functional impairment), check all that apply:

☐ Educational (e.g. Obtaining a degree, taking classes)

☐ Social (e.g. Developing social support system, attending activities and groups in the community)

☐ Vocational (e.g. Obtaining and maintaining employment, resume writing, interviewing)

☐ Self-maintenance (e.g. Managing symptoms, managing money, living independently)

This referral and recommendation has been discussed with the person being referred and they are agreeing to participate.

_____ _____ _____
Practitioner's Signature and Credentials | PLEASE PRINT NAME | DATE

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