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 evaluation (completed by MD) 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.

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.

---

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

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

**Staunton Clinic**
412-749-7330 (Ph)
412-749-7765 (Fax)

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

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

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

**Mon- Yough Community Services (MYCS)**
412-675-6927 (Ph)
412-664-0109 (Fax)

**Western Psychiatric Institute and Clinic (WPIC)**
412-204-9001 (Ph)
412-204-9134 (Fax)
**Section A. ELIGIBILITY CRITERIA**

I. Persons eligible for Service Coordination are adults 18 years of age or older, who have a diagnosis of Schizophrenia or chronic major mood disorder (diagnosis codes 295 and 296 in the DSM) excluding Intellectual Disability or Psychoactive Substance Use Disorder, Organic Brain Syndrome or V-Code.

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

- Admission to State Hospital totaling 60 days within the past 2 years
- Six or more days of inpatient psychiatric hospital within the past year
- Two or more face to face contacts with emergency personnel within past year (i.e. after hours, Crisis Services, ER visits, Police)
- Sporadic Treatment history such as: missed three or more behavioral health appointments or has not maintained medication regime for 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-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
- FSWP
- MBH
- Milestone
- MYCS
- Staunton
- TCV
- WPIC

<table>
<thead>
<tr>
<th>Referral Source Title:</th>
<th>CTT</th>
<th>Inpatient</th>
<th>JRS</th>
<th>ECSC</th>
<th>OP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Name:</td>
<td></td>
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</tr>
<tr>
<td>Phone#:</td>
<td></td>
<td>Cell #</td>
<td></td>
<td>Fax#</td>
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<tr>
<td>Email:</td>
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</tbody>
</table>

**Section C. Service Participant Demographics**

Name

- Last
- First

Alias Name

- Last
- First

Date of Birth

- Age
- SS#
- Gender

Ethnicity

Marital Status

- Single
- Married
- Divorced
- Separated
- Widow
- Partnered

Veteran

- Yes
- No

- If yes, what is the year of discharge?

Current Address

- check here if Homeless
- Zip code

Contact Numbers

- Home:
- Cell:
- Best time to call:

Email Address

Accommodations

- TTY
- Interpreter
- Sign language
- Ambulatory limitations
- Other

Monthly Amount:

Source of Income

- SSI
- SSD
- VA
- Retirement
- Child Support
- Other:

If source of income is pending, please describe and give date of application:

Date of application:

Additional Information:

- Representative Payee Name (if applicable)
- Phone:

- Power of Attorney (if applicable)
- Phone:

Medical Assistance

- Yes
- No

Medical Assistance or ID #

- Medicare

- Yes
- No

Other:

- Medical Assistance or ID #
# SC Adult Referral Form 2015

## Section F. Emergency Contact Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
</tbody>
</table>

Guardian Name if applicable: 

Does participant have a Mental Health Advanced Directive (MHAD) completed within 1 year: [ ] Yes [ ] No

Does participant have a Wellness Recovery Action Plan (WRAP) completed within 1 year: [ ] Yes [ ] No

If participant has a WRAP Plan or MHAD please attach

## Section G. Other Agency/Program Involvement

<table>
<thead>
<tr>
<th>Independent Supports Coordinator</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Coordinator</td>
<td>Phone:</td>
</tr>
<tr>
<td>Community Treatment Team</td>
<td>Phone:</td>
</tr>
<tr>
<td>Certified Peer Specialist</td>
<td>Phone:</td>
</tr>
<tr>
<td>Justice Related Services (JRS)</td>
<td>Phone:</td>
</tr>
<tr>
<td>Probation Officer</td>
<td>Phone:</td>
</tr>
<tr>
<td>Housing Provider</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

[ ] CHIPP [ ] ACSP [ ] CSP/CIT  
If yes please attach plan

Has a referral been made to any housing programs: [ ] Yes [ ] No  
If yes, date referral was made:

Explanation:

## Section H. Mental Health Information

Please include a primary behavioral health diagnosis. Other diagnoses may be included

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Conditions</td>
<td>Medical Conditions</td>
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</tbody>
</table>

Last Psychiatric Eval  
Completed by:

## Section I. Current Outpatient Provider/Services/Supports

<table>
<thead>
<tr>
<th>CURRENT PROVIDER</th>
<th>PROVIDER AGENCY</th>
<th>CONTACT NAME</th>
<th>CONTACT PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Psychiatrist</td>
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<tr>
<td>Outpatient Therapist</td>
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<tr>
<td>Primary Care Physician</td>
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<tr>
<td>Medical Specialist</td>
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</tbody>
</table>

Service Participant Name:
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:

Megan’s Law Registry?
Explain:

Probation?
Explain:

Protection From Abuse (PFA)? Domestic Violence?
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:

### Section K. Legal History

<table>
<thead>
<tr>
<th>PAST, CURRENT, AND PENDING CHARGES</th>
<th>ARREST DATE</th>
<th>RELEASE DATE</th>
<th>CONVICTED</th>
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<tbody>
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<td>No</td>
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</table>

Service Participant Name:
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 ___________________________

Print Name ___________________________ Date ______
Guardian Signature ___________________________

Is Service Participant agreeable to services? □ Yes □ No

If No, explain:

______________________________