Residential Services

2201 East State Street, Hermitage, PA 16148
Phone: 724-699-8633 Fax: 724-981-6198
Libby Purdy: Residential Manager
epurdy@cccmer.org

Referral Form
(MUST be completed in full)

Service Requested:

______CRR ________Respite _______Supportive Housing

Name of Referral:____

Address:____

BSU#:______________________________ Phone:______________________________

SS#:________________________________ DOB:________________________________

Referred by:_________________________ Agency:_____________________________

Date Referred:_______________________ Agency Phone Number:_______________

** Reason for Referral:____

____

____

Sex: M______F_____ Marital Status: M____S______Div._____Wid.___Other______

Size of Household:_________________________________

# of Children:________________________Children living with Referral: Yes_______No___

Current Living Arrangements:

Temporary______________Permanent______________State Hospital__________________

Independent_____________Homeless________________Correctional Facility____________

PCBH__________________With Family_____________Other_________________________

Has the referral ever been evicted? Yes_________ No__________

Why were they evicted?____

Is the referral currently employed or are they currently attending school of any type?

Where:____

Education Completed (Grade) 7 8 9 10 11 12 Other________________________________

Religious Preference:____

Income (Source/Monthly):__________________Medical coverage:___________________

Source of Transportation:____

Community Integration: (clubs, volunteer work, etc.)

____

Most Recent Psychiatric Hospitalization:

Date	Hospital	Primary Symptom
___________	______________________	___________________________
___________	______________________	___________________________
___________	______________________	___________________________

Legal/Issues:____

History of Imprisonment:____

Is consumer on probation:____________parole:___________house-arrest:___________

Parole/Probation Officer:__________________Phone number:____________________

Has the referral ever been convicted of a felony? When and What was the charge(s)?

____

Has the referral ever been convicted for a drug related crime (i.e. possession, selling, etc.)?

When and what was the charge(s)?____

____

Substance Abuse: Current:______________________Past History:_________________

Substance(s) abused:____

Are they currently receiving treatment for substance abuse and where:

____

Physical Disability/Problem(s):

____

****Date of last Physical:_______________**Physical/H&P attached:___________________**

*****MUST BE SIGNED BY PHYSICIAN, not CRNP, PA, or RN!!!**

Psychological Testing Available: Y____N ____

Date of Testing: ___________________ By Whom?_________________________

(Attach copy of psychological to the referral)

Do you Have Diabetes? ______YES _______NO

Can you self-administer your Insulin ______YES _____NO

Would you like to receive Psychiatric care at Community Counseling Center ____YES ____NO

Other Providers Involved: (Psychiatrist, Therapist, PCP, BCM)

____

____

**** Current Medications (Attach a separate sheet if necessary):**

Name	Dosage	Frequency	Doctor

Problem List:

Diagnosis including /ICD 10 Code:

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

GAF (DLA) __________

*****Referrals will not be accepted without the complete Diagnosis /ICD 10 Code and Psychiatrist/Doctor Signature*****

Psychiatrist/Doctor Printed Name:______________________

Psychiatrist/Doctor Signature:_________________________Date:____________

License Number:____________________ Expiration Date:___________________

History of Fire Setting/Arson? Y _________ N________

History of Sexual Offenses? Y_________ N________

History of Suicide Attempts Y _________ N ________

History of Physical Aggression? Y _________ N ________

Towards Others:______________________Towards Self:____________________

If Yes Additional Information Related:____

____

____

I understand that the information provided is true and correct to the best of my knowledge.

I acknowledge that my signature gives permission for the CCC staff to discuss my case with the agency/staff person submitting this referral.

Consumer Signature:________________________________Date:__________________

Referral Signature:_________________________________Date:__________________

****

FOR OFFICE USE ONLY
Actions taken: