BEACON LIGHT
BEHAVIORAL HEALTH SYSTEMS

Mobile Medication Referral Form

Warren/Forrest Office	Clearfield/Jefferson Office	Cameron/Elk/Potter Office
1885 Market Street	6395 Clearfield/Woodland HWY	6395 Clearfield/Woodland HWY
Warren, PA 16365	Clearfield, PA 16830	Clearfield, PA 16830
Phone: 814-230-0151	Phone: 814-230-0151	Phone: 814-230-0151
Fax: 814-817-1453	Fax: 814-817-1453	Fax: 814-817-1453

Referral Name: **Social Security #:** **DOB:**

Address: **Phone #:** **Referral source:**

MA : ____yes ____no; If yes, MA #- ________________________

County funded: ____yes ____no; if yes has the county been contacted? _____________________

Intake scheduled: ____yes, ____no; if yes date intake is scheduled? ________________________

Must Meet Criteria I, II, and III:

I. ☐ The person must be 18 years of age or older and have a primary diagnosis of a serious mental illness (Major Depressive Disorder, Bipolar Disorder, Psychotic Disorder, Schizophrenia, Schizoaffective Disorder) and be prescribed psychotropic medications.

II. ☐ The person is in need of community delivered psychiatric nursing services to prevent the need for more restrictive levels of care and to improve community tenure. The person must meet one of the following:

A. ☐ Receiving case management or other ambulatory services and in need of intensive medication management to prevent the need for an inpatient level of care.

B. ☐ Current inpatient admission or readmission due to non-adherence or inconsistent adherence to the prescribed medication regime.

C. ☐ Initiation or revision of a complex medication regime.

D. ☐ Medical diagnosis that requires coordination of physical and behavioral health issues, including medication management.

E. ☐ Temporary or permanent absence/withdrawal of a primary support who had been assisting the person with medication management.

III. ☐ **An up to date psychiatric evaluation and current list of medications must be provided.**

DIAGNOSIS per DSM V:

RATIONAL FOR MOBILE MEDICATION REQUEST:

SERVICE HISTORY- PREVIOUS AND CURRENT SERVICES, ADMISSIONS, ETC.	
Previous services/Admissions	Provider of Service/ Contact Name & Phone Number (if known)

CURRENT CLINICAL STATUS:

Suicidal or homicidal ideation-____

History of suicidal or homicidal attempts-_______________________________________

Insight/Judgment- ____

Mood and affect-____

PSYCHOSOCIAL INFORMATION:

Education Level-____

Legal history-____

Social supports/housing/employment-_____________________________________

Trauma history-____

<u>Beacon Light Office Use Only:</u>

ADMISSION DATE: **UNITS REQUESTED for 60 days:**