BEACON LIGHT

PEER SUPPORT REFERRAL/ DOCTOR'S RECOMMENDATION

1885 Market Street, Warren, PA 16365

Phone: (814) 817-1400 Fax: (814) 817-1446

THE SECTION BELOW MUST BE FILLED OUT BY REFERRAL SOURCE.

To allow for choice of provider and access to more timely service provision, does the referred individual agree to have this referral shared with Dickinson Center's Peer Support Team / Beacon Light Behavioral Health's Peer Support Team? **Yes** ☐ **No** ☐

NAME: _____ **DATE:** _____

ADDRESS: _____

HOME PHONE _____ **Cell Phone** _____

BSU or MA ID#_____ **Social Security** _____

Date of Birth_____ **Must be 18 or older**

REFERRALSOURCE:_____ **REFERRALS PHONE #:**_____

OTHER AGENCIES INVOLVED:_____

Person being referred agrees to having this referral completed and wants peer support services: YES ☐ NO ☐

Proof of behavioral health diagnosis code (F-CODE) such as Psychiatric or Psychological Evaluation must accompany this referral along with a release of information.

Must Meet One of the Categories A or B or C or D. Category E Must be Met. Please check box(es) that apply.

A. Treatment History:

	Currently resides in state mental hospital or discharged from a state mental hospital in the past 2 years
	2 admissions to inpatient psychiatric unit or crisis residential totaling 20 or more days in the past 2 years
	5 or more face to face contacts with walk-in, mobile, or emergency services within the past 2 years
	1 or more years of continuous attendance in a community mental health or prison psychiatric service within the past 2 years
	History of sporadic course of treatment, inability to maintain med regime or involuntary commitment to outpatient services
	1 or more years of mental health treatment provided by a PCP within the past 2 years

B. Coexisting Condition or Circumstance with Mental Illness

	Psychoactive substance use disorder		
	Intellectual Disability;		
	HIV/AIDSb		
	Sensory disability	Specify:	
	Developmental disability	Specify:	
	Physical disability	Specify:	
	Homelessness		
	Release from criminal detention		

C. Global Assessment of Functioning rating is 50 or below

	IF **YES** LIST **GAF**_____
	No

D. Involuntary Treatment Status

	Met Standards for involuntary treatment in the past 12 months preceding this assessment.	Specify:	

PLEASE COMPLETE PAGE 2

Revised 10/28/2022

Beacon Light

PEER SUPPORT REFERRAL/RECOMMENDATION

NAME _____ **BSU** _____

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E. **Must** have a moderate to severe functional impairment that limits performance in **at least 1** of the following: **Please check & describe.**

☐ **Educational** ***Describe this impairment*** _____

☐ **Social** ***Describe this impairment*** _____

☐ **Vocational** ***Describe this impairment*** _____

☐ **SELF-MAINTENANCE** ***Describe this impairment*** _____

Must have a diagnosis of a serious mental illness (SMI) as defined in the Mental Health Bulletin - Office of Mental Health 94-04 Serious Mental Illness: Adult Priority Group

DIAGNOSES: (Must have a diagnosis for Schizophrenia, Major Mood D/O, Psychotic Disorder NOS, or Borderline Personality D/O)

Behavioral Health Diagnosis & F CODE:

Behavioral Health Diagnosis & F CODE:

Behavioral Health Diagnosis & F CODE:

Medical Conditions/Physical Health Issues:

Medical Conditions/Physical Health Issues:

Psychosocial/Environmental Concerns:

MUST BE SIGNED BY A LICENSED PRACTIONER OF THE HEALING ARTS. Please circle which applies: Psychiatrist, Physician, Licensed Psychologist (PhD or M.A. level), Certified Nurse Practitioner (CRNP), Physician Assistant.

Signature:_____ **Credentials** _____

Printed Signature_____ **Date:**_____

By signing this form, the Practitioner has reviewed the referral, attests to its accuracy, and recommends the above mentioned participant for the Peer Support Program with Beacon Light.

Please fax COMPLETED PAGES (2) TO ASHLEY CARPENTER (814) 817-1446 ALONG WITH OTHER SUPPORTING DOCUMENTATION

If you have any questions, please contact Ashley Carpenter at (814) 817-1400 ext. 1626 or Gabriel Magill at (814) 817-1400 ext. 1637