

WESTMORELAND COUNTY
Services Team for Adults in Recovery (S.T.A.R.)
REFERRAL FORM

INDIVIDUAL INFORMATION

Individual: _____ Date of Birth: _____ Age: _____ Gender: _____
 Address: _____ City: _____ State: PA Zip: _____
 Home Phone Number: _____ Alternate Number: _____ SS#: _____
 Veteran: Yes No
 Significant Supports/Others:

Name	Relationship	Contact Phone Number	Invite to Mtg.	
			Yes	No

REFERRAL SOURCE

Referring Agency: _____ Contact Person: _____
 Business Phone: _____ Fax Number: _____
 Signature: _____ Date: _____

REASON FOR REFERRAL

Referral to TSH Review at risk mental health individual TSH Discharge Other: _____
 Briefly explain: _____

INSURANCE INFORMATION

Medical: _____ Behavioral: _____ Medicare: Yes No MA Referred: Yes No If Yes, Date: _____

Individual: _____ Date: _____

FINANCIAL INFORMATION

Source	Amount

Total Monthly Income: _____

MENTAL HEALTH PROFILE

Axis I : _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Present Psychiatric Medication:

Name	Dose	Frequency	Prescribing Physician

Prescribing Psychiatrist: _____ Phone Number: _____

Therapist/Counselor: _____ Phone Number: _____

MEDICAL PROFILE

Other Medical Condition(s): _____

Present Medications (other than psychiatric):

Name	Dose	Frequency	Prescribing Physician

Primary Care Physician: _____ Phone Number: _____

Individual: _____ Date: _____

DUAL DIAGNOSIS

A. Mental Retardation: Yes No **If Yes:**

Type of Service	Contact Name	Address	Phone	Dates of Service	Invite to Mtg.	
					Yes	No
Supports Coordination						

B. Drug and Alcohol: Yes No **If Yes: Drug of Choice:** _____

Type of Service	Contact Name	Address	Phone	Dates of Service	Invite to Mtg.	
					Yes	No

SERVICE UTILIZATION

A. Inpatient Hospitalizations in past year? Yes No **If Yes:**

Facility	Dates of Service	Overall Length of Stay

B. Respite Placements in the past year? Yes No **If Yes:**

Facility	Dates of Service	Overall Length of Stay

C. Other mental health services:

Type of Service	Contact Name	Address	Phone	Dates of Service	Invite to Mtg.	
					Yes	No
Case management						

Individual: _____ Date: _____

D. Other involved services:

Type of Service	Contact Name	Address	Phone	Dates of Service	Invite to Mtg.	
					Yes	No

CRIMINAL INFORMATION

Has the individual ever been convicted of a felony? Yes No If Yes briefly explain: _____

Are there any charges pending? Yes No If Yes briefly explain: _____

Name of Probation/Parole Officer: _____ Contact Number: _____

ADDITIONAL COMMENTS

Upon completion of referral form, please fax to Westmoreland County MH/MR at 724-830-3571. Meeting date will be coordinated by Westmoreland County CHIPP Coordinator. Please call 724-830-3617 with any questions.

MEETING DATE (WILL BE ASSIGNED BY CHIPP COORDINATOR)

S.T.A.R. Meeting Date: _____ Time: _____

Location (WCSI or Excelsa Health Inpatient): _____