WESTMORELAND COUNTY
***S*ervices *T*eam for *A*dults in *R*ecovery (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.		If NO, reason why
			YES	NO	
			YES	NO	
			YES	NO	
			YES	NO	

REFERRAL SOURCE

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

REASON FOR REFERRAL

Referral to TSH **Review At-risk Consumer** **Request for Higher Level of Care** **Other:** _____
Briefly Explain: _____
_____
_____
Anticipated outcome of STAR Referral: _____
_____

INSURANCE INFORMATION

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

Individual: _____ **Date:** _____

FINANCIAL INFORMATION

Source	Amount

Total Monthly Income: _____

BEHAVIORAL 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

Any Medical Condition(s): _____

Present Medications (other than psychiatric):

Name	Dose	Frequency	Prescribing Physician

Primary Care Physician: _____ **Phone Number:** _____

Individual: _____ **Date:** _____

DUAL DIAGNOSIS

A. Intellectual/Developmental Disabilities (I/DD): Yes No If Yes:

Type of Service	Contact Name	Address	Phone	Dates of Service
Service Coordination				
DDTT				

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

Type of Service	Contact Name	Address	Phone	Dates of Service

SERVICE UTILIZATION

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

Facility	Commitment (201/302)	Dates of Service	Overall Length of Stay

B. Current and Previous Community B/H Services:

Type of Service	Y/N	Provider/Contact Name	Phone	Dates of Service	Reason *(if)* Service Ended
Case Manager					
ACT Team					
Outpatient					
IOP/EOP					
Psych Rehab					
MM&E					
Rep Payee					
ACE Program					
Peer Support					

Individual: _____ **Date:** _____

C. Current or Previous Residential Services:

Type of Service	Y/N	Provider/Contact Name	Phone	Dates of Service	Reason *(if)* Services Ended
LTSR					
CRR					
Enhanced Shared Housing					
Supportive Housing					
DAS					
New Foundations					
Fairweather Lodge					
PCH					
DOM Care					
Housing Supports					

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 BH/DS at 724-830-3571 or e-mail to lesniej@westmoreland.swsix.com Meeting date will be coordinated by Westmoreland County CHIPP Coordinator. Please call 724-830-3618 with any questions.