Beacon Light Behavioral Health System
Peer Support Services Referral Form

1885 Market Street, Warren, PA 16365 or 800 East Main Street, Bradford, PA 16701
Phone: (814) 817-1400 Fax: (814) 817-1446

Referral Information

Name:	Date of Birth:	Insurance/MA #:
Phone Number:		Social Security #:
Address:		County:
Referring Agency or Contact Person:		Phone #:
Person being referred agrees to having this referral completed and wants peer support services: ☐ YES ☐ NO		

DIAGNOSES: Must have a DSM 5 diagnosis in the SMI population (Schizophrenia, Major Mood Disorder, Psychotic Disorder, etc) and may not include any prior diagnoses from the DSM - IV with NOS specifiers or Rule Outs. Please include a primary behavioral health diagnosis. Other diagnoses may be included.

Behavioral Health Diagnosis (MUST include F Code):

Medical Conditions/Physical Health Issues:

Reason for Referral: Must have a moderate to severe functional impairment that limits performance in 1 of the following. Please List specific concerns/recommended goals/focus:

Social Functioning needs-

Educational Functioning needs-

Vocational Functioning needs-

Self-Maintenance needs-

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

A. Treatment History:		**B. Coexisting Condition or Circumstance with Mental Illness**	
☐	Currently resides in a state mental hospital or discharged from state mental hospital in the past 2 years	☐	Psychoactive substance use disorder
☐	2 admissions to inpatient psychiatric unit or crisis residential totaling 20 or more days in the past 2 years	☐	Intellectual Developmental Disorder
☐	5 or more face to face contacts with walk-in, mobile, or emergency services within the past 2 years	☐	HIV/AIDS
☐	1 + years of continuous attendance in a community mental health or prison psychiatric service within the past 2 years	☐	Sensory disability (describe):
☐	History of sporadic course of treatment, inability to maintain med regime or involuntary commitment to outpatient services	☐	Developmental disability (describe):
☐	1 or more years of mental health treatment provided by a PCP within the past 2 years	☐	Physical disability (describe):
C. Involuntary Treatment Status		☐	Homelessness
☐	Met Standards for involuntary treatment in the past 12 months preceding this assessment.	☐	Release from criminal detention

D. Must have a moderate to severe functional impairment that limits performance in 1 of the following (please check all that apply)							
☐	**Educational**	☐	**Social**	☐	**Vocational**	☐	**Self-Maintenance**

MUST BE SIGNED BY A LICENSED PRACTITIONER OF THE HEALING ARTS: Psychiatrist, Physician, Licensed Psychologist (PhD or of M.A. level), Certified Nurse Practitioner (CRNP), Physician Assistant, LCSW, LCP

LPHA Signature and credentials: _____

Printed Signature: _____ **Date:** _____