RecoveryInSight Inc.
Seeing the person and not the illness.
1681 Crown Avenue, Suite 12
Lancaster, Pennsylvania 17601
Phone: 717-517-8552/Fax: 717-517-8557

Recommendation for Peer Support Services by a Practitioner of the Healing Arts

(MUST be completed by: Physician, Licensed Psychologist, Certified Registered Nurse Practitioner, or Physician Assistant)
NOTE: This form is valid for 60 days from the date it is signed by a Practitioner of the Healing Arts.

Consumer/Client/Member's Name: _____ DOB: _____ BSU#/MAID# _____

Admission Guidelines

Referred individual MUST meet criteria for serious mental illness, which is defined as:
A condition experienced by persons 18 years of age and older who, at any time during the past year, had a diagnosable mental, behavioral, or emotional disorder that met the diagnostic criteria within the current DSM and that has resulted in functional impairment and which substantially interferes with or limits one or more major life activities. Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illness. Substance use disorders and developmental disorders are not included.

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

To qualify for Peer Support Services, the Consumer/Client/Member MUST meet the following:

Reason for referral: ☐ Educational ☐ Vocational ☐ Social ☐ Self-Maintenance

☐ Consumer/Client/Member is 18 years or older (required)

☐ Consumer/Client/Member chooses to receive Peer Support Services (required)

☐ Presence of or a history of serious mental illness as defined above (required)

☐ Functional impairment that interferes with or limits one or more major life activities (required—*check all that apply*)

- **☐ Social, behavioral, cognitive, communicative, or adaptive skills**
- **☐ Role functioning including basic daily living skills (e.g. eating, bathing, dressing)**
- **☐ Instrumental daily living skills (e.g. maintaining household, managing money, using transportation, taking prescribed meds.)**
- **☐ Functioning in social, family, vocation/education**

As the Consumer/Client/Member is interested in a referral to Peer Support Services and the above criteria are met, I am making the recommendation for Peer Support Services.

_____	_____	_____
Name (Printed)	Professional Title	Date
_____	_____	_____
Signature	Agency	Address

Please return this completed form to Recovery InSight, Inc. via fax or mail. Any questions regarding this form, please contact us at the above telephone number.

(7/10; 10/10; 10/14; 2/17; 10/17)