RecoveryInSight Inc.
Seeing the person and not the illness.
1525 Oregon Pike, Suite 801
Lancaster, PA 17601
Phone: 717-517-8552
Fax: 717-517-8557

Peer Support Services Referral Form

IDENTIFYING INFORMATION *(ALL fields must be completed at time of referral. Please print clearly.)*

Name: _____ Date Referred: _____

Date of Birth: _____ Social Security Number: _____

PerformCare ☐ Yes ☐ No MAID # *(10 digits):* _____ ***OR*** County BSU#: _____

Gender: ☐ Male ☐ Female ☐ Another Gender _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Race: ☐African American ☐Caucasian ☐Asian/Pacific Islander ☐ Native American ☐Latino ☐ Other: _____

Primary Language: _____ Can the individual speak and understand English? ☐Yes ☐No

Living Status: ☐ Lives independently ☐ Lives with family ☐ Lives with parent/guardian ☐ Lives with others ☐ Supervised setting ☐ Homeless

Address:_____

Phone Number: Home ( ) _____; Cell ( ) _____; Work ( ) _____

OK to leave a message? ☐ Yes ☐ No

PSYCHIATRIC INFORMATION: **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. For youth age 14 up to age 18, there must be the presence of or a history of a serious emotional disturbance or serious mental illness. Substance use disorders and developmental disorders are not included.***

In what ways could this individual benefit from Peer Support Services?

_____
_____
_____
_____

PROVIDERS

Case Manager: Name_____ Telephone Number: _____

Agency_____

Psychiatrist: Name_____ Telephone Number: _____

Agency_____

Therapist: Name_____ Telephone Number: _____

Agency_____

Rev. 7/12; 10/14; 10/15; 10/17; 5/18; 5/19; 7/19

MEDICAL INFORMATION

Significant Health Problems/special needs:

_____
_____
_____
_____

Date of Last Medical Exam: _____

Primary Care Physician (PCP): Name_____ Telephone Number: _____

Address: _____

Does the individual have a substance use history? ☐ No ☐ Yes *(if Yes, please describe:)*

_____
_____

CURRENT SERVICES AND/OR SUPPORTS *(Indicate ALL services the individual regularly utilizes)*

☐ Day Program: _____
☐ Probation/Parole: _____
☐ Vocational Program: _____
☐ Psychosocial Rehab *(i.e. Clubhouse, Drop-in Center)*: _____
☐ Other: _____
_____

☐ Alcohol/Drug Treatment Services: _____
☐ Alcoholics/Narcotics Anonymous
☐ Educational Program: _____
☐ No activity

The following documents are needed to complete the referral process *(to avoid delay, please provide all requested information)*:

☐ **Peer Support Recommendation Form-Signed by a Practitioner of the Healing Arts** *(Physician-M.D. or D.O., Licensed Psychologist, Certified Registered Nurse Practitioner (CRNP), or Physician's Assistant (P.A.)*

REFERRAL SOURCE INFORMATION

Name of Person Completing Referral Form: _____ Telephone Number: _____

Agency: _____ Relationship to Individual being Referred: _____

Signature of Referred Individual*:* _____

Signature of Parent/Guardian (*if referred individual is under age 18*): _____

Individual Prefers (Check ONE): ☐ Male Certified Peer Specialist ☐ Female Certified Peer Specialist ☐ Doesn't Matter

Completion of this form acknowledges that referred individual has been made aware of all providers of Peer Support Services in both Lancaster and Lebanon Counties:

Lancaster County	Lebanon County
Recovery InSight, Inc. (717) 517-8552	Recovery InSight, Inc. (717) 517-8552
WellSpan Philhaven (717) 221-9610	WellSpan Philhaven (717) 221-9610