RecoveryInSight Inc.
Seeing the person and not the illness.
1525 Oregon Pike, Suite 801
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 (MD or DO), Licensed Psychologist (PhD or PsyD), Certified Registered Nurse Practitioner (CRNP), Physician's Assistant (PA or PA-C), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT)
NOTE: This form is valid for 180 days from the date it is signed.

Name: _____ DOB: _____ BSU# or MAID# _____

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 aged 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 without the presence of SMI are not included.***

DSM diagnosis(es) and ICD 10 code(s) MUST BE COMPLETED:

Reason for referral (MUST be completed):

☐ Educational ☐ Vocational ☐ Social ☐ Self-Maintenance

The Client/Member MUST meet the following criteria (MUST be completed):

☐ Age > 18 years with presence of or a history of serious mental illness (SMI)

☐ Age 14-17 years with presence of or a history of SMI or Serious Emotional Disturbance (SED)

☐ Consumer/Client/Member chooses to receive Peer Support Services

Functional impairment that interferes with or limits: ***(Check all that apply)***

☐ A person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills;

☐ Role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing);

☐ Instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and

☐ Functioning in social, family, and vocational/educational contexts.

By signing below, I agree that the Client/Member agrees to referral to Recovery InSight, Inc. for Peer Support Services and the above admission criteria have been met.

Name Of Practitioner (Printed)	Professional Title	Agency
Signature	Date	Address Line 1
Provider NPI#	Provider MA ID#	Address Line 2

Please return this completed form to Recovery InSight, Inc. Contact us at (717) 517-8552 with any questions regarding this form.
(Rev. 9/22; 3/24)