



The Friends Connection

"Making the Right Connections"

Mental Health Association of Southeastern Pennsylvania

Psychiatric Rehabilitation Referral Information

Criteria for Service: Must have a co-occurring diagnosis of mental health and substance abuse and reside in Lower Merion, Norristown Proper or Abington. Or are a member of base service units of 464, 465, 466

To make a referral, please complete this form, mail or fax to the Friends Connection of Montgomery County. The Friends Connection will contact you upon receipt of this form. Thank you

Date of Referral: _____

Person Making Referral - Name: _____ Phone: _____

Referral Agency (Name & Address): _____

Consumer Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Type of Residence: _____ BSU #: _____

Reason for Referral: _____

DIAGNOSIS

(please list all diagnoses, including mental health and drug/alcohol, from most recent psychiatric evaluation)

Date of Evaluation: _____

AXIS I:

MH Diagnosis: _____ DSM-IV Code: _____

D&A Diagnosis: _____ DSM-IV Code: _____

AXIS II: _____ DSM-IV Code: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

Please check the domain for which you are referring to the Friends Connection for Psychiatric Rehabilitation Services:

____ Social Domain ____ Self-Maintenance: Living Domain ____ Vocational Domain
____ Self-Maintenance: Managing Illness & Wellness Domain (Recovery) ____ Educational Domain

SUBSTANCE USE

Consumer's Drug of Choice: _____ Other Substances: _____

Amount/Frequency/Duration of Use: _____

INSURANCE INFORMATION

Medical Assistance Provider: _____ Phone #: _____

Medical Assistance #: _____ Social Security #: _____

Primary Care Physician: _____ Phone #: _____

Behavioral Health Provider: _____ Phone #: _____



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COMMUNITY SUPPORT

TCM Agency & Phone: _____ ICM/RC Name: _____

(circle)

Length of Time in TCM: _____

Day Program: _____ # of Days: _____ Times: _____

Day Program Address, Phone, and Contact Person: _____

Is program attended regularly? YES ___ NO ___

If no Day Program, how does consumer spend his/her day? _____

Other Supports: _____

12-Step Meeting Attendance: ___ YES ___ NO Is consumer in therapy? ___ YES ___ NO

Does consumer regularly attend scheduled appointments? ___ YES ___ NO

MENTAL HEALTH OUTPATIENT TREATMENT

OP MH Agency: _____ Address: _____ Phone: _____

Medications: ___ YES ___ NO Does consumer take medications as prescribed? ___ YES ___ NO

List Medications: _____

SUCIDALITY

Is there a past history of suicidal behavior? ___ YES ___ NO If yes, explain: _____

Current Suicidal Ideation: ___ YES ___ NO If yes, explain: _____

SERVICE UTILIZATION

Dates of Last Hospitalization – Admit: _____ DC: _____ Hospital: _____

Length of Stay: _____ Reason for Admit: _____

Number of Mental Health Crisis Contacts in Past 3 Months: _____ (CRC, Mobile Emergency Team, etc.)

Number of Days Inpatient (psychiatric) in Past 3 Months: _____

Number of Days in Detox in Past 3 Months: _____

Number of Days in Residential Rehab in Past 3 Months: _____ (Inpatient Substance Abuse Treatment)

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