

MERCY BEHAVIORAL HEALTH
CHILD AND ADOLESCENT PHP REFERRAL FORM
 Phone (412) 697-0736 and Fax (412) 320-2398

NAME		DATE OF REFERRAL	
DATE OF BIRTH		MA/CCBHO#	
SOCIAL SECURITY #		SCU/COUNTY #	
PHONE NUMBER		OTHER INSURANCE/POLICY #	
PARENT/GUARDIAN		ADDRESS	

REFERRAL SOURCE/RELATIONSHIP	AGENCY	PHONE NUMBER

PRESENTING NEEDS/REASON FOR REFERRAL:

DIAGNOSIS (IF ASD IS DX- IT MUST BE LEVEL 1. LEVEL 2 & 3 AND IF CONSUMER IS ID/IQ LOWER THAN 70 CONSUMER WILL NOT BE ACCEPTED INTO THE PHP)
DSM 5 DIAGNOSIS:
MEDICAL DIAGNOSIS:
CURRENT MEDICATIONS – PLEASE INCLUDE THE STRENGTH, DOSAGE AND TIME ADMINISTERED
1.
2.
3.

Online Referral

4.
5.

SPECIAL NEEDS: MEDICAL ISSUES/ALLERGIES/SPECIAL FOOD NEEDS

PLAN FOR DISCHARGE: (Disposition must be clear and all consumers must have a place to go upon D/C. If consumer does not have a case manager, a referral for case management services should be made.)

SCHOOL	GRADE	REG ED/SPEC ED	DISTRICT

CURRENT SERVICES		
TYPE OF SERVICE	NAME/AGENCY	NUMBER
PSYCHIATRIST		
THERAPIST (SPECIFY TYPE- OP, FBMH, BHRS, SBT)		
CASE MANAGER		