PITTSBURGH MERCY
CERTIFIED PEER SPECIALIST
REFERRAL FORM

PART 1

What Peers offer: Peers have both past and current mental health recovery experience and with this lived experience, they are able to provide support, encouragement and guidance to those who are currently in mental health treatment and they are able to help promote sustained and long-term recovery.

Email referral form to: CPSReferrals@pittsburghmercy.org

Please Print Legibly

Name of Person Referred_____Date of Referral_____

SS#_____ DOB_____ Phone _____

Address_____

Referral Source Name _____Title _____Phone_____

Program/Agency_____ Email Address: _____

ADMISSION REQUIREMENTS:

1. Part 1 Referral completed by a service provider
2. Copy of a Psychiatric Evaluation (within 2 years) or Treatment Plan must be attached
3. Part 2 Recommendation from a listed type of Licensed Provider must be attached

Check one*: ___*copy of Psych Eval attached: (Within 2 years) ___ ***copy of Treatment Plan attached***

1. List current MH diagnosis: _____

2. List current Medication: (if none put N/A)_____

_____

Person referred has **moderate to severe functional impairment that limits performance** in at least one of the following domains: (Check all that apply and briefly describe)

____Social/Interpersonal Roles: _____

____Employment/Vocational: _____

____Educational: _____

____Self- Maintenance: Managing Illness and Wellness_____

____Self-Maintenance: Independent Living_____

Name of Person Referred_____

Please Print Legibly

Other Information:

Indicate the person's involvement in other behavioral health or related services:

___Service Coordination Contact Person: _____ Phone #: _____

___PHP/OP Contact Person: _____ Phone #: _____

___Residential Contact Person: _____ Phone #: _____

___Other Service (specify): _____ Contact Person: _____Phone #: _____

___Other Service (specify): _____ Contact Person: _____Phone #: _____

Check recent (past two years) involvement in any of the following, and briefly describe: (attach additional sheet, if needed)

Inpatient MH Hospitalization __N/A __Yes, describe_____

Medical or physical health concerns __N/A __Yes, describe _____

Forensic/Legal Involvement: __N/A __Yes, describe _____

Drug and Alcohol: __N/A__ Yes, describe _____

Aggressive/Destructive Behavior: __N/A __Yes, describe_____

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Questions for Referral Source

1.Peer Support Services is a voluntary activity. Have you discussed this referral with the person? _____Yes _____No. If no, please explain how you know the person wants to participate in this program.

_____

2. To what degree is this person cooperative and dependable in working with services provided?
___Very cooperative and dependable ___Somewhat cooperative ___Not very cooperative or dependable

3. To what degree is this person aware of issues related to his or her mental illness, such as diagnosis, symptoms, medications, prodromal symptoms, etc.?
___Not very aware ___Somewhat aware ___Very aware

4. Note any cognitive and/or intellectual impairments which may impact this person's functional roles.
___ Attention ___ Memory ___ Problem solving ___ Other _____

5. Please note person's strengths (skills, accomplishments, resources, etc.): _____

6. Note any goals the person has in the employment, housing, education, social roles, or wellness management domains.

_____

LICENSED PRACTITIONER'S RECOMMENDATION FOR CERTIFIED PEER SPECIALIST SERVICES

PART 2

Please Print Legibly

I recommend:_____ DOB:_____

who has the following serious mental health diagnosis:_____
(Please spell out diagnosis)

To receive Certified Peer Specialist Service:
The individual referred has a moderate to severe impairment and needs to develop skills and supports in the following areas. Please check the appropriate boxes and list the functional impairments:

	Social:
	Employment:
	Educational:
	Wellness/Health:
	Independent Living:

Please specify which type of listed <u>Licensed</u> Clinician you are:

	Medical Doctor		**Physician's Asst.**		**Cert. Registered Nurse**		**Psychologist**
	Clinical Social Worker		**Professional Counselor**		**Marriage & Family Therapist**		

Licensed Clinician's Signature _____ Date: _____

Clinician's Printed Name _____

<u>Please Note:</u>

To be eligible to receive CPS services, a person must have a Serious Mental Illness, defined by regulations as: "any person, 18 or 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 supportive services are considered to have a serious mental illness. **<u>Substance use disorders, developmental disorders and neurodevelopmental disorders are not included.</u>**"