Chart #: ________________
Document Type: CPS 12

WESTMORELAND CASEMANAGEMENT AND SUPPORTS, INC.

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Phone: 724-837-1808 Fax: 724-837-4345

CERTIFIED PEER SPECIALIST REFERRAL

Referral Date: ______________________________

Client Name: ______________________________ **D.O.B.:** __________________

Parent/Guardian Name (if under 18): ______________________________

Address: ______________________________

Telephone number(s): ______________________________

The following information must be completed by a psychiatrist, licensed psychologist, primary care physician, physician's assistant, or licensed nurse practitioner and include the client's diagnosis and functional impairment.

1. Does the individual and/or parent/guardian agree to receive Peer Support Services?
Yes _____No _____

2. A. Diagnosis/Adults 18+: The individual you're referring must have a diagnosable mental, behavioral, or emotional disorder that meets diagnostic criteria within the current Diagnostic and Statistical Manual/DSM. **Individuals with primary Substance use disorders and developmental disorders alone are not included.**
Please specify the diagnosis: ______________________________

B. **Diagnosis/Children 14 – 17 years of age:** The individual you're referring must have a Serious Emotional Disturbance/SED. SED is defined as a diagnosable mental, behavioral, or emotional disorder of sufficient duration that meets diagnostic criteria specified within the current DSM. **Individuals with primary Substance use disorders and developmental disorders alone are not included.**
Please specify the diagnosis: ______________________________

Please attach a copy of the client's most recent evaluation or med check, verifying diagnosis.

3. Functional Impairment: Difficulties that substantially interfere with or limit an individual 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; instrumental living skills; and/or functioning in social, family, and vocational/educational contexts.

Please select any of the following domains in which there is a moderate to severe functional impairment, give a description, and note the overall severity:
Educational _____ Social _____ Vocational _____ Wellness/Self-Maintenance _____
Severity: Moderate _____ Severe _____

Please give a description of the functional impairment:

____
____
____
____

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4. Possible Barriers (check all that apply):
Mobility _____ Wheelchair _____ Speech _____ Language _____ Probation______ D& A Issues_________
Sight _____ Hearing _____Physical Health Issues_____ Transportation_______ Reading________

Other/Additional information: ____

5. Mental Health Treatment Facility: ____

NOTE: The NPI and (13 digit) MA Promise ID # of the Practitioner signing off on the referral must be included on this referral for the referral to be valid.

6. I am a: psychiatrist _____licensed psychologist _____ licensed nurse practitioner _____
primary care physician _____physician's assistant _____, and I recommend Peer Support services.

____________________________________ / ____________________________________
Print name of Physician/ Practitioner of the Healing Arts **Signature of Physician/practitioner of the Healing Arts** **Date**

____
Name of Facility in which Physician/Practitioner of The Healing Arts works **Phone Number**

____________________________________ / ____________________________________
NPI # **(13 digit) Medical Assistance Promise ID #**

____
Signature of Peer Support Supervisor **Date**

____
Signature of WCSI Mental Health Professional **Date**

<u>Please attach a copy of the client's most recent evaluation or med check, verifying diagnosis</u>.