WCSI
Westmoreland Casemanagement and Supports Inc.
134 Industrial Park Road Greensburg, PA 15601

Targeted Case Management Referral

Internal Use Only:
Chart #: _____
TCM (28)

Client Name:	Date of Referral:	Date WCSI Received:
Home Phone : Alternate Phone:	DOB:	Marital Status:
Address:		
Parent/Guardian (if applicable)		
Insurance Provider:	Insurance ID/Member Number (if known):	

Primary Reason(s) For Referral:

Treating Provider(s)	**None**	**Last Seen**	**Phone**
Psychiatrist:	☐		
Outpatient Therapist:	☐		
Primary Care Physician:	☐		

Current System Involvement/ Services Being Received: *(Check all that apply)*

☐ CYS	☐ Drug & Alcohol	☐ MST	☐ ACT/CTT	☐ Housing
☐ Juvenile Justice	☐ Veterans	☐ Family Based	☐ PHP/IOP	☐ Vocational Services
☐ Criminal Justice	☐ Special Educational Services	☐ IBHS	☐ Rep Payee	☐ Personal Care/Nursing Home
☐ Aging	☐ Adult Protective Services	☐ SAP Services	☐ Other:	

Current Diagnosis:	**Code**	**Current Medications** *(May attach additional pages)*

History of Psychiatric Hospitalization(s) if known: *(List from most recent. Include State Hospital)*		
Name of Facility or Program:	From:	To:

Potential Risk Factors *(Check any/all that apply)*

☐ Hx of suicidal ideation	☐ Hx of homicidal Ideation	☐ Hx of Inpatient Hospitalization(s)	☐ Victim of domestic or other violence	☐ Current D/A Use
☐ Self-Injurious Behavior	☐ Hx of Physical Aggression	☐ Frequent encounters w Emergency or Crisis Services	☐ Difficulty taking medication(s) as prescribed	☐ Difficulty engaging in services

TO BE ELIGIBLE FOR TARGETED CASE MANAGEMENT INDIVIDUALS MUST:

1) Have a primary mental health diagnosis within the DSM-IV-R or subsequent revision, excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-Code and
2) Have a need established by one of the following conditions: 1) Six or more days of psychiatric inpatient treatment in the past twelve months; 2) Met standards for involuntary treatment within the past twelve months; 3) Currently receives or in need of mental health services and receives or is in need of services from two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc.; 4) Have missed at least 3 community mental health service appointments, or have had two or more face-to-face encounters with crisis intervention/emergency services personnel within the past twelve months, or have existing documentation that s/he has not been able to maintain his/her medication regimen.

Thank you for your referral. Please attach most recent mental health, psychiatric or psychological evaluation and any relevant documentation/summary note validating eligibility as above. If you have any questions, or need assistance filling out this form, please contact us directly at 724.837.1808. Completed form may be sent to confidential fax at 724.837.4345 or securely emailed to bhreferrals@wcsi.org.

Signature of Provider: _____ **Title:** _____

Print Name: _____ **Phone:** _____ **Date:** _____