



wesley family services

**Adult/Child Referral for Blended Service Coordination (Case Management)
Westmoreland/Armstrong County**

Consumer Name:				Date of Referral:		
Previous Name(s):						
DOB:		SSN:		Age:	Male	Female
Race/ Ethnicity:		Primary Language:		Marital Status:	Single	Married
					Divorced/Separated	Domestic Partner
					Widow	Partner
Are you a Veteran:				Yes	If Yes, Year and type of discharge:	
				No		
Current Address:						
Phone Number:				Best time to call:		
Financial Information/Source of Income:						
If applied for and not yet receiving potential source of income, please describe and give date of application:						
Do you currently have a Representative Payee:				Yes	If Yes, Please Provide Name and contact Information:	
				No		
Health Insurance Information						
Medical Assistance:		Yes	Medicare:	Yes	Other:	
		No		No	(please describe)	
Emergency Contact Information						
Name:				Relationship:		
Address:						
Phone Number:						
Do you have a Guardian:				Yes	If yes, Please provide Name and contact information:	
				No		



Referral Source		
Person making Referral (Name and Title):		
Representing which Agency/committee:		
Address:		
Phone:	Fax:	Email:
Relationship to Consumer:		
MENTAL HEALTH INFORMATION (please attach a recent psychiatric evaluation or Doctor's signature to verify diagnosis completed within past 12 months.)		Diagnostic Code:
Behavioral Health		
Behavioral Health		
Medical Conditions		
Medical Conditions		
Last Psychiatric Eval.		Completed By:
ELIGIBILITY CRITERIA: Persons eligible for Service Coordination are adults 18 years of age or older, who have a diagnosis of schizophrenia or other chronic major mood disorder excluding Intellectual Disability or Psychoactive Substance Use Disorder, Organic Brain Syndrome, or V-Code and must have at least one of the following: (please check off and provide detail if known)		Details if known:
Admission to State Hospital totaling 60 days within past 2 years		
Six or more days of inpatient psychiatric hospital within the past year		
Two or more face to face contacts with emergency personnel within the past year (i.e. after hours, crisis services, ER visits, police)		
Sporadic treatment history such as: missed three or more behavioral health appointments or has not maintained medication regimen for 30 days		
Transfer from another Service Coordination Provider		
Currently receiving or in need of MH services or in need of services from two or more human services agencies or public systems such as drug and alcohol, vocational rehabilitation, criminal justice, etc.		



Reason for referral-please indicate specific needs (please indicate how service participant could benefit from Service Coordination):

RISK FACTORS (please indicate any risk factors such as suicidal attempts, self-injurious behaviors, Megan's Law, probation, domestic violence or past displays of physical aggression, homeless or risk of eviction, major medical concerns):

SIGNATURE OF SERVICE PARTICIPANT: