CORRY COUNSELING OF LECOM HEALTH
BLENDED CASE MANAGEMENT
REFERRAL FORM

IDENTIFYING INFORMATION		
Date of referral:	Consumer Name:	
Street Address:	City:	Zip Code:
Date of Birth:	Age:	SS#:
Home Phone:	Cell Phone:	MA#:
Marital Status: □ Single □ Married □ Divorced/Separated □ Widowed		
Race: □ Hispanic □ Non-Hispanic		
Veteran: □ Yes □ No	History of Homelessness: □ Yes □ No	

REFERRAL SOURCE	
Person Making Referral (Name and title):	Phone:
Representing Agency:	

DSM DIAGNOSIS	
Diagnosed by:	Date of diagnosis:
Problem List 1	
Problem List 2	
Problem List 3	
Problem List 4	
GAF	
Current Risks:	
Are you aware if the consumer owns or has any access to weapons? □ No □ Yes, please explain:	

ADULT TREATMENT HISTORY	
□ Six or more days of inpatient mental health treatment in past 12 months	□ Met 302 standards in past 12 months
□ At least three missed community mental health service appointments or documentation the individual has not maintained his/her medication regimen for a period of at least 30 days	□ Two or more face-to-face with Crisis Services in past 12 months
□ Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems	□ History of State Hospitalization within past 12 months. Discharge Date: _____

□ Adults who were receiving case management services as children	□ Adults – GAF 60 and below	
□ One or more years of continuous attendance in a community mental health or prison psychiatric service within the past two years	History of Compliance: □ Poor □ Moderate □ Good □ Unknown	Adherence to Current Treatment: □ Poor □ Moderate □ Good □ Unknown

Print name of person making referral: _____

Signature of person making referral: _____ Date: _____

Please include a current, doctor signed, psychiatric evaluation dated within the last year.

SEND REFERRAL TO: Laurie Holthouse MS,
Corry Counseling of LECOM Health
45 East Washington St.
Corry, PA 16407
PHONE: 664-7761 ext. 138
FAX: (814) 664-4020

ADDITIONAL INFORMATION REQUIRED IF CHILD:

DSM dx

PRIORITY GROUP CRITERION

□ Age: <18, or <21 enrolled in Special Education

□ DSM Dx: Resulting in Significant Functional Impairment

□ Involuntary Treatment (within the past 12 months)
Please Describe: _____

Other Current System Involvement (Check all that apply, list details i.e. Facility, Placement, Physician, Case Manager etc.):

□ Child and Youth Services:_____

□ Developmental Disabilities: _____

□ Drug & Alcohol Treatment: _____

□ Special Education:_____

□ Juvenile Justice: _____

□ Chronic Health Condition: _____

At Risk Criteria (Check all that apply):

□ Homeless/Living in a Shelter □ Drug/Alcohol Dependency
□ Physical/Sexual Abuse □ SAP Referral

SMI Parent: Last Name: _____ First Name: _____ DOB: _____

Client Name: _____

ID#: _____

BCM NEED FOR SERVICE CHECKLIST:
Please check all areas that apply in support of this referral. Include any additional information in the comment section on page 4.

MENTAL HEALTH

___ Symptoms of mental illness negatively impact daily functioning

___ Demonstrates pattern of mental health treatment non-compliance (missed appointments, meds)

___ Recent CRU &/or RTFA placement

___ Needs assistance with accessing & maintaining treatment & support services

MEDICAL

___ No needs in this area/has medical provider

___ Significant medical conditions & not receiving care

___ Problem effectively communicating with medical providers

___ Needs to be linked to medical providers: PCP/Dental/Vision/Home Health

___ Erratic compliance with medical treatment recommendations

HOUSING

___ No needs in this area

___ Homeless/shelter placement

___ Pending Homelessness

___ Inadequate/unsafe housing

___ Transitional housing

INCOME

___ No needs in this area

___ Insufficient/no income

___ Needs DPW cash benefits

___ Needs SSD application &/or appeal assistance

___ Needs payee services

ADL

___ No needs in this area

___ Inability to advocate for self

___ Inability to respond to danger

___ Poor personal hygiene habits

___ Prompts needed to perform ADL (Laundry, housekeeping, meal preparation)

EDUCATION/VOCATION

___ No needs in this area

___ Loss or pending loss of employment

___ Needs assistance in employment search

___ Seeking part-time employment

___ Seeking GED/other academic options

Client Name: _____

ID#: _____

DRUGS & ALCOHOL

___ No needs in this area

___ Use pattern severely interferes with functioning

___ Non-compliance or inability to follow treatment

___ Currently receiving or recently discharged from D&A treatment

___ Is pregnant

Currently prescribed or abusing the following:
☐ Suboxene ☐ Methadone ☐ Vivitrol

FORENSIC

___ No needs in this area

___ Currently on probation/parole

___ Pending legal charges: _____

___ Attends Treatment or Family Dependency Court

___ Recent release from criminal detention

___ CROMISA involvement

___ Sex offender/Megan's Law Registry

SOCIALIZATION

___ No needs in this area

___ Has no community support system/relationships

___ Lacks natural support system

___ Is unfamiliar with community resources

___ Interested in increasing social interactions

Please provide any additional comments below: