COUNTY OF ALLEGHENY

RICH FITZGERALD
COUNTY EXECUTIVE

CASE MANAGEMENT DETERMINATION AND REFERRAL FORM

Client's Name _____ Sex _____ SS# _____ DOB _____

Address _____ ZIP code _____ Phone _____

Facility _____ Admission date _____ Discharge date _____

Referral person _____ Referral person's phone number _____

The purpose of this section is to determine treatment and non-treatment needs. If there is a need, identified during the assessment process, in one or more of the following domains the client **must be offered** a referral or the need must be addressed at the treatment facility. Check the appropriate domain to symbolize a client's need.

DOMAINS		**DOMAINS**	
Drug and Alcohol	☐	Employment	☐
Physical Health	☐	Education	☐
Emotional / Mental Health	☐	Family / Social	☐
Living Arrangements / Housing	☐	Legal Status	☐
Basic Needs (Food, Clothing, Utilities)	☐	Life Skills	☐
Transportation	☐	Child Care	☐

Total number of domains _____ /12 Referral offered? ◯ Yes ◯ No Referral accepted? ◯ Yes ◯ No*

*Reason for not accepting referral (if applicable)

_____

Would you like service offered at a later date? ◯ Yes ◯ No ◯ N/A

How were identified needs addressed? Explain (if applicable)

_____

Date of referral (if applicable) _____

_____ _____

Client's signature/ Date Staff's signature/Date

RESET ALL

DEPARTMENT OF HUMAN SERVICES/OFFICE OF BEHAVIORAL HEALTH
BUREAU OF DRUG AND ALCOHOL SERVICES

*PLEASE KEEP A COPY OF THIS FORM IN THE CLIENT RECORD
*IF THE CLIENT NEEDS INTENSIVE CASE MANAGEMENT SERVICES PLEASE FAX THIS FORM TO DIVERSIFIED CARE MANAGEMENT AT 412-253-1384

UPDATED 7/18/12