Community Care Behavioral Health
Specialized Services Referral Form and Instructions

NOTE: Only one service can be requested at a time: Do not choose both Mobile Medication and Enhanced Clinical Service Coordination

1. The referral source should complete this form for any new referral. All sections of this document **must be thoroughly completed and legible** in order to make a determination of services. Items should not be left blank- please indicate N/A where appropriate. Also, a **current psychiatric evaluation and a list of the most recent medications must be faxed with the referral.**

2. The signature of the person being referred is required indicating that they understand a referral is being made. The signature must be no more than 30 days from the date of referral. If the person is unable to sign, the referral source must state if it is due to current symptoms, physical limitations, or other. Also include the name and phone number of the person who discussed the referral with the individual being referred.

3. Fax the completed referral to Community Care at: **1-888-251-0087**.
   For questions regarding the referral process, contact Community Care by phone at 1-888-251-2224.

4. Referrals will be reviewed by Community Care for Medical Necessity Criteria. Referrals for county funded persons will be forwarded to a designated Allegheny County OBH liaison for review of Medical Necessity Criteria.

5. Community Care or Allegheny County OBH will follow up with the referral source to review the referral and request additional information if needed.

6. If the individual being referred does not meet Medical Necessity Criteria, Community Care/OBH recommendations will be made for an alternative and appropriate level of support and treatment necessary to address the needs of the person being referred.

7. If the individual being referred meets Medical Necessity Criteria, Community Care will forward the referral form to the provider and confirm the date that the specialized services team plans to make initial contact with the individual. This date and the team assigned will be relayed by Community Care to the referral source.

8. Once the specialized services are approved and a provider is assigned, the referral source should obtain a signed Release of Information and fax the clinical records (including the most recent psychiatric evaluation and list of medications) directly to the assigned provider. Records should be faxed within 5 days of assignment

Community Care Specialized Services Referral Form:
(Select Only One Service)

Enhanced Clinical Service Coordination ☐

Psychiatric Mobile Medication Services ☐

Demographic, Identifying and Contact Information:

Name: _____ DOB: _____

MA ID#: _____ SS#: _____

Current Address: _____

Current Phone #'s: _____

Guardian Name: _____ Guardian Phone #: _____

Guardian Address: _____

I certify that this specialized service has been explained to me and I am willing to accept these services at this time

Signature of Person Referred_____

Date_____

If no signature obtained, reason why: _____

_____

Person who completed referral/explained specialized services to person being referred (include name and phone):_____

Include information regarding the clinical rationale for requesting specialized services:

_____

_____

_____

_____

_____

*****Attach the most recent psychiatric evaluation to this referral prior to sending it to Community Care Behavioral Health.******

I. Diagnosis:

Must have a primary diagnosis of a serious mental illness (Major Depressive Disorder, Bipolar Disorder, Psychosis NOS, Schizophrenia or Schizoaffective Disorder)

Axis 1_____

Axis 2 _____

Axis 3 _____

Axis 4 _____

Axis 5 Current GAF: _____Past Year: _____

List of All Current Medications and Dose or attach a medication list (Do not attach a MAR):

_____

_____

_____

_____

_____

_____

List any current medical problems:

_____

_____

II. Services:

A. List Hospitalizations, Incarcerations, and Emergency Encounters, in last 12 month's (list in current order):

Type/Facility *Dates*

1. _____

2. _____

3. _____

4. _____

B: Treatment Services in past 5 years (IOP, Partial ,CTT, etc). Please provide reason service was discontinued:

1. _____

2. _____

3. _____

C. Current Services:

Current	Provider/Agency	Contact Name	Contact Phone No.	Date of Initial Contact	Next Appointment
Outpatient Psychiatrist					
Service Coordinator					
Outpatient Therapist					
Primary Care Physician					
Medical Specialist					
CTT					

III. List Substance Abuse/Dependence:

Type Used *Frequency* *Date of last use*

1. _____
2. _____
3. _____
4. _____

IV. History of Life Threatening Suicide Attempts/Life Threatening Self Harm

List Specific Behaviors/Method *Date* *Outcome* *(admitted to, etc)*

1. _____

2. _____

3. _____

4. _____

V. List current or history of legal charges. List if on probation or parole. Provide history of impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to others (ex. assault, rape, arson).

List Impulsive/Acting Out Behavior *Date* *Outcome* *(arrest, etc)*

1. _____

2. _____

3. _____

VI: Assessment of Strengths:

1. _____

2. _____

VII. Support system: List current natural support system (family, friends, or social programs) and the frequency of contact. If there were natural supports who are no longer involved, provide a brief reason why no longer involved.

List Supports/Relationships *Frequency of Contact/Last Contact* *Reason No Contact*

1. _____

2. _____

3. _____

VIII. Identify psychotic or mood related symptoms person experiences when symptomatic that interfere with daily functioning:

1. _____

2. _____

3. _____

IX: Current Housing Placements and History (List in chronological order):

1. _____

2. _____

3. _____

To be completed by Community Care/OBH

Accepted/Approved for Assignment ( ):

Specialized Service _____

*Assigned Team*_____

*MCO Reviewer*_____*Date*_____

*Allegheny County OBH Reviewer*_____ *Date*_____