MENTAL HEALTH ASSOCIATION
of Northwestern Pennsylvania
1101 Peach Street • Erie, PA 16501-1639
814/452-4462 • 800/840-7961
www.mhanp.org

PEER SPECIALIST/SUPPORT SERVICES
REFERRAL FORM

Date of Referral: _____

I am recommending peer support services as medically necessary for:

_____

_____ _____
Signature of Physician, licensed psychologist, CRNP or NP, PA Date

_____
Printed Name and Title

DO NOT SPECIFY PROVIDER FOR PEER SUPPORT ON THIS FORM

Information on the Referred Individual

Name: _____ Date of Birth: _____ Sex: M/F

Address/City/State/Zipcode:_____

Telephone Number: _____

BSU and/or MA Number: _____

Social Security Number: _____

Is the consumer motivated to pursue recovery? Please circle 1 response:

Very **Needs to understand more about recovery**

Somewhat **Don't know**

Consumer Name: _____BSU/MA#: _____

Date of Birth: _____

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Reason(s) for referral/areas of need:

_____

_____

_____

Signature of person completing this form _____ Date_____

Position & agency affiliation

If possible, please include copies of all insurance cards of consumer.

When complete, please send to:

David F. Wooledge
Peer Support Team
Mental Health Association of Northwestern Pennsylvania
1101 Peach Street
Erie, PA 16501
(814) 452-4462 ext. 117 cell (814) 897-3178
(814) 314-1094 FAX

Admission, provision of services, and referrals of mental health consumers shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age or sex.

Revised August 2014