Mental Health Association of Northwestern PA
Peer Support Services Referral Form

Date Referral Sent:	Date Referral Received:

REFERRAL INFORMATION	
Name of person being referred:	**Name of Person Making Referral:**
Address:	**Agency:**
City/State/Zip:	**Email Address:**
Home Phone:	**Office Phone:**
Cell Phone:	**Cell Phone:**

IDENTIFYING INFORMATION	
DOB:	**Gender:**
MA #:	
MCI #:	
SS #:	

DESIRED OUTCOMES (GOALS) AND/OR REASON FOR REFERRAL

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.

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First Name of person being referred:	Last Name of person being referred:

CURRENT DSM V DIAGNOSIS	
Diagnosis Given By:	Date:
Behavioral Health description:	Code:
Behavioral Health description:	Code:
Behavioral Health description:	Code:
Physical Health description:	Code:
Mental status:	
Mental status:	
Mental status:	
GAF Score:	

SIGNATURES & TITLES	
Signature & Title: [Licensed Practitioner of the Healing Arts (LPHA)]	**Date:**
Typed or Printed name: [LPHA]	
Signature & Title: [person completing referral]	**Date:**
Typed or Printed name: [person completing referral]	
Signature: [person being referred]	**Date:**
Typed or Printed name: [person being referred]	

Send referral to:

Theresa Abbey, Peer Support Team Leader
Mental Health Association of NWPA | 1101 Peach Street | Erie, PA 16501
Office: (814) 452-4462, ext. 133 | Cell: (814) 897-3200
Fax: (814) 314-1094 | E-mail: tabbey@mhanp.org