Grapevine Center Incorporated
Peer Specialist Referral Form

(All fields must be completed at time of referral)

140 North Elm Street, Suite B
Butler, PA 16001-4820

Phone (724) 283-1704
Fax (724) 283-8635
e-mail grapevine@zoominternet.net

Date Received ____ /____ /____

Client Name: _____ Maiden (Birth) Name: _____

Date of Birth: _____ Soc. Security #: _____ BSU #: _____

Address: _____

_____

Home Phone #: _____ Alt. Phone #: _____

Current Insurance: _____ MA#: _____

****

Referred by (Agency): _____ Contact (Referring) Person: _____

Address: _____

_____

Phone #: _____ Date of Referral: _____

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Criterion for Program referral: Person must be 18 years or older and has been diagnosed with a Serious Mental Illness of sufficient duration to meet diagnostic criteria specified within DSM-V that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities.

Primary Diagnosis: _____ DSM-V/ICD Code:_____

Secondary Diagnosis: _____ DSM-V/ICD Code: _____

How would peer benefit from peer specialist services? (Please check domain and brief explanation of recommendations)

_____ Education _____

_____ Self-maintenance _____

_____ S o c i a l _____

_____ Vocational _____

****

_____ _____ _____

Signature of Practitioner of Healing Arts Print Practitioner Name Date

_____ _____

Practitioners PROMISe Number Practitioners NPI Number

Per Medicaid requirements the service must be recommended by a licensed practitioner of the healing arts which may include a physician, a licensed psychologist, a certified registered nurse practitioner or a physician's assistant. Practitioners PROMISe number and NPI number must be included.

Current Involvements: _____

☐ Blended Case Manager (name & phone): _____

☐ Payee (name & phone): _____

☐ Therapist (name & phone): _____

☐ Family (name & phone): _____

☐ Physician/Psychiatrist (name & phone): _____

☐ Other: _____

A Psychiatric or Psychological Evaluation must accompany this referral. In the space provided, describe needs, preferences (prefers working with male/female etc.), and other information which would help in matching to a peer specialist or engaging peer in peer specialist service:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of person completing referral _____

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For Official Use Only

Peer Staffed To: _____

Date Assigned: _____

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Revised 8/18/17 (Al)