Stairways behavioral health

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Erie, PA 16505

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Mobile Medication Referral Form

CONSUMER INFORMATION

NAME:	DOB: SSN:	MA Recipient ID:
Phone: Alternate Number:	Home Address:	

Is the consumer currently inpatient or in residential services? YES ☐ NO ☐

If yes, please include the following information

Facility Name:	Contact Name:
Facility Address:	Contact Number: Date of Admission: Tentative Discharge Date:

REFERRING INFORMATION

Referral source:	Agency Affiliation:
Contact Number:	Referral Date:

Reason for referral: (How is the consumer managing his/ her current medication regimen? Has mismanagement of meds resulted in hospitalizations?)

Based on the consumer's needs, please indicate the urgency for first contact:

☐ ROUTINE (within 7-14 days) ☐ URGENT (within 5 business days)

If URGENT , please explain:

DIAGNOSTIC INFORMATION

Behavioral Health:

Behavioral Health:

Behavioral Health:

Medical Conditions / Physical Health Issues:

Medical Conditions / Physical Health Issues:

Current Symptoms:

Medical Conditions and Allergies:
Are there any current or past drug & alcohol concerns? YES ☐ NO ☐ If yes, please explain:
Is the consumer currently enrolled in treatment? YES ☐ NO ☐ If yes, where:

EXISTING SERVICES/ SUPPORTS

Psychiatrist	**Primary Care Physician**	**Blended Case Manager**
Name:	Name:	Name:
Contact #:	Contact #:	Contact #:
Dentist	**Other**	**Other**
Name:	Name:	Name:
Contact #:	Contact #:	Contact #:

SAFETY CONCERNS

Please note that the Mobile Med Staff will be providing services in consumers homes. Are there any safety concerns or risk factors that the mobile staff should be aware of?
Please explain:

MEDICATIONS

Is the consumer prescribed psychotropic medications? YES ☐ NO ☐
* If **no**, the consumer would not be eligible for Mobile Med Services *
If **yes**, please attach current med list to this referral form. Or write in the meds by name & dosage in the space below:

Referring Signature: _____ Date: _____

Consumer Signature: _____ Date: _____