Referral Packet - PA and NJ Programs



Please send referral back to <u>pfetterly@keycommres.com</u>

If you have any questions Please contact Paige Della Camera our admissions coordinator at <u>pfetterly@keycommres.com</u> or 570-702-8048.

CONFIDENTIAL

Persons completing this document and the persons receiving the disclosed information may only further disclose consistent with the authorized purpose for which it is intended or disclosed (MH 1748-[3]).

Please answer the following questions related to the consumer:

| Referral Name: | | DOB: | | Age: | |
|------------------------------|--|---------------------------|--------------|------|---|
| Nototral Name. | | Sex: | | | • |
| County of Funding: | | Approve Source: | d Funding | | |
| Referred by: | | Contact | information: | | |
| Services: | □Residential □Behavioral Support □Community Participa □Life Sharing / Family □Employment Support □Supporters Broker □In-home and Commu □Supports Coordinatio | Living ts nity/ Cam | pion | | |
| Desired Service Location: | | | | | |
| Reason for Referral: | | | | | |

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| Guardianship Status: | □Self □Other: Guardian Name and relationship |
|----------------------|--|
| Representative Payee | □Self □Other: Guardian Name and relationship |
| Diagnosis: | |
| | |
| | |
| Diet: | |
| | |
| Allergies: | |
| | |

Medications: (current medications. Please list below or attach a list)

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Referral Packet

| ledical Summary: |
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| ast Hospitalization (medical and Psychiatric): |
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| sychiatric Presentation: |
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Please attach the following required documents if available:

- Current Individual Support Plan (for all Services)
- Current SIS Assessment
- Guardianship Paperwork
- Current Psychiatric Evaluation
- Any Psychological Assessments

- Life Time Medical information
- Current Physical/Immunization Record
- Upcoming Medical/Dental Appointments
- Current Medication List/Current Prescriptions
- · Behavior Plan, if applicable

Thank you for your referral!

We look forward to serving you, the individual and the community.