Lehigh Valley Drug and Alcohol Intake Unit: 35 E Elizabeth Ave Suite 42, Bethlehem Pa 18018
P: 610-849-2406 F: 610-419-6061 (please email referral form to Jscott@lvintake.org)

Recovery Support Services Referral Form Part I

Client: _____ Date: _____ File# _____
(Intake Unit Staff ONLY)

Address: _____ Phone Number: (Home) _____

_____ (Other) _____

☐ ***Mark here if client will require a Spanish speaking CRS**

Social Security Number: _____ Date of Birth: _____

Will the client need assistance in getting Part II completed? (PHA signature) ☐ **yes** ☐ **no**

Emergency Contact Person and Relation: _____

Phone Number: _____

Referral Contact and Title: _____ Phone Number: _____

Agency/Facility: _____

CURRENT LOC (circle one): 1 2.1 2.5 3.1 3.3 3.5 3.7 4

Agency Providing These Services: _____ Phone Number: _____

Admission Date: _____ Discharge Date: _____

Recovery Support Services Domains	Based on information obtained at assessment, including client and clinician perceptions; is the client in need of assistance in the following areas? (*Check all that apply)*
EDUCATION / VOCATION	
EMPLOYMENT	
PHYSICAL HEALTH	
DRUG AND ALCOHOL	
EMOTIONAL / MENTAL HEALTH	
SOCIAL	
LIVING ARRANGEMENTS / HOUSING	
LEGAL STATUS	
BASIC NEEDS (food, clothing, utilities)	
RECOVERY SUPPORTS	
PARENTING	
TRANSPORTATION	
SAFETY	
SPIRITUALITY/OPTIMISM	
FAMILY (PRIMARY PARTNERSHIP)	
ACCESS TO SERVICES	
HEALTH INSURANCE	
	Domains Identified _____/17

Referred for Recovery Support Services: ☐ **Yes** ☐ **No**

Referral Accepted by Client: ☐ **Yes** ☐ **No**

Willingness to work collaboratively toward a goal of recovery: ☐ **Yes** ☐ **No**

Behavior Health Insurance Carrier:

☐ Magellan – Lehigh County
☐ Magellan – Northampton County
☐ Northampton County Funded
☐ Other: _____

_____

_____

TO BE COMPLETED BY A LICENSED PRACTIONER OF THE HEALING ARTS (LPHA)

(Physician, Physician's Assistant, CRNP, LCSW, LPC)

In accordance with State Requirements, a Certified Recovery Specialist must be recommended as a medically necessary service.

Individuals **PRIMARY** diagnosis must be a Substance Use Disorder. **This form must be completed within SIXTY DAYS of referral date.**

SUBSTANCE USE DIAGNOSIS (PRIMARY):

_____

_____

_____

Does this individual have a Mental Health Diagnosis? If yes please list:

_____

_____

_____

Please describe the functional impairments that dictate the need for a Certified Recovery Specialist. A functional impairment is considered as;
A person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills ♣ Role functioning in one or more major life activities including basic daily living skills ♣ Instrumental living skills (maintaining household, managing money, getting around in the community, taking prescribed medication) ♣ Functioning in social, family, and vocational/ educational contexts:

_____

_____

_____

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_____

Print Name

_____

Signature

_____

Date

AGENCY USE ONLY (do not write in this space):

Date Received:

First Contact Attempt:

Assigned Date:

Revised 6/24/20