CORRY COUNSELING OF LECOM HEALTH
MEDICATION SUPPORT PROGRAM
REFERRAL FORM

IDENTIFYING INFORMATION		
Date of referral:	Consumer Name:	Date of Birth:
Address:	City:	Zip Code:
Marital Status:	Home Phone:	Cell Phone:
Race:	SS#	MA#

Individual must be at least 18 old, a resident of Erie County, and diagnosed with a serious mental illness.

REFERRAL SOURCE		
Person making referral (name and title):	Agency:	Phone:
Treating psychiatrist:	□ Physician is in agreement with referral to Medication Support Program	

✓	REASON FOR REFERRAL		
	Support needed to take medication as prescribed		Complex medication regime
	Safety concerns about medication storage		Need for medication education
	Loss/absence of support person who assisted with medication management		
	Medical diagnosis that requires close coordination of services, including medications		
	Other:		

PSYCHIATRIC DIAGNOSIS	
Diagnosed by:	Date of diagnosis:

CHECK APPLICABLE SERVICES AND LIST PROVIDERS		
✓	Services	Provider Name and Agency
	Outpatient counseling	
	Blended Case Management services	
	Substance Abuse treatment	
	Inpatient psychiatric treatment within the past 12 months	
	Residential substance abuse services within the past 12 months	

Does client have any medical concerns? □ Yes □ No If yes, please describe:

_____

_____

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_____

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Are you aware of any safety concerns in the home? □ Yes □ No If yes, please describe:

_____

_____

Signature of person making referral: _____ Date: _____

Please include a copy of the psychiatric evaluation and recent medication check notes with the referral.

SEND REFERRAL TO: Laurie Holthouse MS, Corry Counseling of LECOM Health
45 East Washington St.
Corry, PA 16407
PHONE: 664-7761 ext. 138
FAX: (814) 664-4020