M·H·Y FAMILY SERVICES

521 Route 228 Mars, PA 16046
Telephone 724-625-3141 Fax 724-625-2226
info@mhyfamilyservices.org

Referral Form

Diversion Acute Stabilization (DAS)

Referral Date: ☐ Previous MHY Client

Client Name:		MA#:	
SS#:		DOB:	

Other Insurance:		Phone #:	
Address:		Policy #:	

Parent/Legal Guardian

Name:		Phone #:	
Address:		Phone #:	
County:			

Referral Source

Name:		Agency:	
Relationship:		Phone #:	
		Fax #:	

Presenting Need/Reason for Referral (Please note the intensity and frequency of symptoms/behaviors.)

Current Interventions Utilized to Assist in Stabilization

Has there been an increase in intensity of current services (e.g. in-home services, psychiatric appointment, etc.) within the past 72 hours? ◯ Yes ◯ No

DSM-5 Diagnosis

Psychiatric Diagnoses:	
Medical Diagnoses:	
Psychosocial Stressors:	

Client Name:		MA#:	
SS#:		DOB:	

Plan for Discharge

Where will the client be discharged to upon discharge from the DAS program?	

Current Medications and Dosages

If coming from the hospital	
When was the last PRN?	
What medication was used?	

Medical Information

Special Needs, Medical Issues, Allergies, Diet, etc.:			
Approximate Height:		Approximate Weight:	

☐ Confirmation of Current Physical (No more than one year from the admission date.)
Actual copy of the physical is required upon admission.

Educational Information

Contact Person and Title:		Grade:		◯ Current ◯ Last Completed
School Name:		Phone #:		
District:		Fax #:		
Please check one:		◯ Regular Education	◯ Special Education	

All Other Programs/Agencies Involved (JPO/CYS, BHRS, FMHS, SC)

Name:		Phone #:	
		Fax #:	
Name:		Phone #:	
		Fax #:	
Name:		Phone #:	
		Fax #:	
Service Coordinator/ Case Manager:		Phone #:	
		Fax #:	

Client Name:		MA#:	
SS#:		DOB:	

Checklist

- ☐ Psychiatric Evaluation (within the past 6 months)
- ☐ Insurance Information/Copy of Insurance Card
- ☐ Current Medication (14 day supply)
- ☐ Current Copy of Service Plan
- ☐ Completed Referral Form
- ☐ Verification Psychiatrist Agrees with Admission (Required CCBHO)
- ☐ Discharge Summary (if coming from an inpatient stay or out of home placement)
- ☐ Verbal Verification of Consumer's Willingness to Participate
- ☐ Necessary Releases of Information
- ☐ Place to go Upon Discharge
- ☐ Physically Healthy at this time
- ☐ Authorization from Managed Care

Date Authorization Received:	
Authorization #:	
Date Range:	
Number of Days:	
Name of BHMCO Representative Authorizing Admission:	

MHY Family Services Staff Completing

Print Name: _____

Signature: _____ Date: _____

Please fax or email referral to:

Sherry Cochran
MHY Family Services
521 Route 228
Mars, PA 16046
scochran@mhyfamilyservices.org
Phone: 724-625-3141 x282
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