Awaken
MENTAL HEALTH CASE MANAGEMENT

COMPLETED REFERRAL MUST INCLUDE:
- Eligibility Checklist
- Awaken Mental Health Referral Form
- Psychiatric Evaluation/Psychological Summary less than 6 months old that includes eligible primary diagnosis
- Medication List
- Physical (if provider has this on file)

Eligibility Checklist

Please complete thoroughly (by a treatment provider ONLY) and mail, email, or fax to:
Dave Frey, Program Director, 19 N. 6th Street, Suite 300, Reading, PA 19601
Phone: 610-988-0669 • Fax: 610-375-9010 • Email: dfrey@awakenmentalhealth.org

Kindly follow up with a call or email to Dave once referral is sent.

CLIENT: _____ Date: _____

Please check off all that apply, to ensure client is ELIGIBLE for case management services (eligibility established by OMHSAS and CCBH)

MUST MEET THESE TWO

- ☐ Client is 18 years of age or older
- ☐ Diagnosis within DSM IV R (or succeeding revisions thereafter), excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-Code

Treatment History (MUST meet at least ONE of the criteria)

- ☐ Currently is being discharged from a PA State Hospital
- ☐ 6 or more days in a psychiatric unit during the past 12 months
- ☐ Met criteria for an Involuntary Civil Commitment (302) at least once in past 12 months
- ☐ Currently receiving or in need of mental health services and receiving or in need of services from 2 or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc.
- ☐ Refusal of or inability to adhere to medication regimen and/or missing 3 or more appointments with mental health provider in past 6 months
- ☐ 2+ Crisis contacts in past 12 months.

19 North 6th Street
Suite 300
Reading, PA 19601

Phone: 610-988-0669
Fax: 610-375-9010

awakenmentalhealth.org

Begin The Journey.

Referral Form

CONSUMER: _____

Last *First* *M.I.*

ADDRESS: _____

_____

PHONE(s): _____ RACE: _____ ETHNICITY: _____

SSN: _____ DOB: _____ Sex: ☐ M ☐ F

Referral Source and Phone/Email: _____

Health Insurance Provider: _____

Primary Care Physician and Phone #: _____

Primary Language Spoken: _____ Marital Status: _____

Veteran Status: _____

Emergency Contact(s): *Name:* *Phone #:* *Relationship to Consumer:*

_____

Current Income and Source of Income: _____

Current Involvement with Treatment? ☐ YES ☐ NO

If yes, where/level of care? _____

Highest grade completed/highest education level achieved? _____

Current Needs: (Check all that apply)

- ☐ Housing
- ☐ Employment/Job Training
- ☐ Daily Living Skills
- ☐ Mental Health Treatment
- ☐ Basic Needs (food, clothing, etc.)
- ☐ Physical Health/Medical
- ☐ SUD Treatment
- ☐ Transportation
- ☐ Legal

Best time and place to contact client: _____

ADDITIONAL COMMENTS/INFO:

_____

_____

_____

CURRENT Diagnoses:
****Documentation must be attached to this referral form****
****Please use current ICD—10 coding*

MUST send current list of medications and psych eval or psych summary less than 6 months old.

Please check and sign the following:

☐ I have discussed case management services with _____.

Client Name

☐ _____ has voluntarily consented to receive services.

Client Name

_____

Referring Therapist, Doctor, Social Worker Signature *Date*

Referral Source Email Address:_____

**(Once a case is assigned, an email will be sent to the referral source confirming case assignment and assigned case manager's contact information)*