

BEAVER COUNTY DRUG AND ALCOHOL CASE MANAGEMENT

260 Ohio River Blvd. Baden, PA 15005

Date of Refe	erral:						
Individual's Name:			DOB:		MA Number:		
Individual's	s Address:		Individual's P			Phone Numb <u>er:</u>	
Referring A	Agency:	Person Referring:		R	eferral Phone Nu	umber:	
		ADMIS:	SION CRITE	RIA			
•	the eligibility requirements for Dent copy of psychiatric evaluation	•	•	nt. Please co	mplete this referra	I form in its entire	ety and attach
		Must Mee	et Criteria I c	and II			
I. DIAG	NOSIS						
retard	nosis within DSM V (or subsequent dation, or organic brain syndrome CHED TO THIS REFERRAL SHEET.						
II. REAS	ON FOR REFERRAL (please ch	eck all areas tht ap	ply)				
□ P	regnant	Women with Children		dose Survi ,	Veteran		
	Other High Risk Behaviors:						
III. LIFE D	OOMAINS (please check all a	reas of need that a	nnly)				
	ousing 🗖 Child Care 🗖 Educ	ation/Vocati a En	mploym ht al Health	Basic N€a		Alcohol and amily/Social	Other Drug Life Skills
			AGENCIES			a,, 000.a.	2.10 0110
Agency Nam	e:				Agency	Phone:	
Address:							
-							
Please ho	ave individual sign Release of		ur agency a upervisor	nd fax with	referral form to 7	24-869-2029, /	Attn: DACM
Individual Sig	nature:		орогиясь.			Date:	
Clinician Sign						Date:	
c Individ	dual accepted into program	Signature:				Date:	
c Indivi	dual not accepted into program	Signature:				Date:	
Contributing f	actors related to denial of admis	sion at this time (if ap	plicable):				
			-				
•	nce with referral source:						
Merakey Staf		poke to; emailed; fax		Referral Sour		on D a	te
and informed	the referral source that	was/was r	not admitted	to the DACM	1 program at this ti	me.	