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Erie, PA 16505

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Mobile Medication Referral Form

CONSUMER INFORMATION

NAME:	DOB:	MA Recipient ID:
	SSN:	
Phone:	Home Address:	
Alternate Number:		

Is the consumer currently inpatient or in residential services? YES NO

If yes, please include the following information

Facility Name:	Contact Name:
Facility Address:	Contact Number:
	Date of Admission:
	Tentative Discharge Date:

REFERRING INFORMATION

Referral source:	Agency Affiliation:
Contact Number:	Referral Date:
Reason for referral: (How is the consumer managing his/ her current medication regimen? Has mismanagement of meds resulted in hospitalizations?)	
Based on the consumer's needs, please indicate the urgency for first contact: <input type="checkbox"/> ROUTINE (within 7-10 business days) <input type="checkbox"/> URGENT (within 72 business hours) <input type="checkbox"/>	
If URGENT or EMERGENCY, please explain:	

DIAGNOSTIC INFORMATION

Behavioral Health:
Behavioral Health:
Behavioral Health:
Medical Conditions / Physical Health Issues:
Medical Conditions / Physical Health Issues:
Current Symptoms:

Medical Conditions and Allergies:

Are there any current or past drug & alcohol concerns?

YES

NO

If yes, please explain:

Is the consumer currently enrolled in treatment?

YES

NO

If yes, where:

EXISTING SERVICES/ SUPPORTS

Psychiatrist	Primary Care Physician	Blended Case Manager
Name:	Name:	Name:
Contact #:	Contact #:	Contact #:
Dentist	Other	Other
Name:	Name:	Name:
Contact #:	Contact #:	Contact #:

SAFETY CONCERNS

Please note that the Mobile Med Staff will be providing services in consumers homes. Are there any safety concerns or risk factors that the mobile staff should be aware of?

Please explain:

MEDICATIONS

Is the consumer prescribed psychotropic medications?

YES

NO

* If **no**, the consumer would not be eligible for Mobile Med Services *

If **yes**, please attach current med list to this referral form. Or write in the meds by name & dosage in the space below:

Please attach a current psychiatric evaluation and current medication list

Referring Signature: _____

Date: _____

Consumer Signature: _____

Date: _____