Consumer ID

102151_____

PeerRising Referral Form

Consumer Information

Consumer Name: _____ Email Address: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone number: (____)_____ Gender: _____ DOB: ____ /____ /____ Age: ____

If Minor:

Guardian Name: _____ Email Address: _____

Guardian Phone Number: (_____)_____ Is Guardian aware of referral: Y / N

Medicaid recipient: Y / N Medicaid Provider: _____ Medicaid Number: _____

Social Security #: _____-_____-_____

Referral Eligibility Criteria

☐ Consumer is a legal resident of Nebraska
☐ Consumer is experiencing or may experience a behavioral health crisis because of COVID-19.
☐ At admission or within 30 days of admission, consumer has a mental health diagnosis under the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association Developmental Disorders or Psychoactive Substance Use disorders are included as well.
If available, identify diagnosis: _____
☐ This pattern is a development because of the COVID-19 pandemic or has increased because of the COVID-19 pandemic.
☐ Consumer demonstrates a need for support in coordinating treatment, recovery, and rehabilitation options in the community.

Referring Party Type

☐ Health Department
☐ Behavioral Health Provider
☐ Self-referred
☐ Other _____
☐ School
☐ Caregiver
☐ Emergency Personnel

Name of Referring Party: _____ Date: ___/___/____ Time: _____AM/PM

Phone number: (_____)_____ Email: _____

REFERRALS CAN BE EMAILED OR FAXED TO:

Amanda Pearson EMAIL: apearson@irnebraska.org **FAX: (308)708-2397**

FPSS Assigned: _____ Date: _____

Supervisor Signature: _____ Date: _____

Date GPRA Completed:____ /_____ /_____ Date Entered into CDS: _____ / _____ / _____

Initials: _____