Shawn McGill, MSW Consulting Inc.
1406 Mt. Royal Blvd. Glenshaw, PA 15116
Phone: 412-781-3829; Fax: 412-774-2240
Email: referrals@shawnmcgillmsw.com ; website: www.shawnmcgillmsw.com

Referral Form

Client Information ***(person referred for service)***

Name (First):	**Name** (Last):	
Address:		
City:	**State**:	**Zip Code**:
Phone:	**Email**:	
DOB:	**MA #**	
Is There a Legal Guardian? ☐YES ☐NO	**Guardian's Name & Contact Info:**	
Living Situation: ☐Residential ☐ Lifehsaring ☐ Supported Living ☐ w/ Family ☐ Own ☐ Other:		

Nature of Service Requested (list all that apply):

- ☐ Risk Screening for Problematic Sexual Behaviors (sexual offender)
- ☐ Intensive Consult (problematic sexual behaviors or female offender)
- ☐ Ongoing Behavioral Support/Consultation
- ☐ Other (please list):
- ☐ Outpatient Therapy
- ☐ Functional Behavior Assessment (FBA)
- ☐ Sexual Consent Screening

Please note the following: once referrals are received careful review is completed to determine whether or not the service can be fulfilled. Communication with the referring party will occur to indicate the status of the referral. Within 3-5 business days our team will identify whether or not we are able to accept the referral based on staffing availability. Services should **not** be authorized until we have communicated whether or not we have accepted the referral. If referral acceptance is communicated, our services will begin once the service authorization and/or service contract is received.

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Funding Source (list all that apply):

- ☐ ODP Consolidated Waiver (list funding county):
- ☐ Adult Autism Waiver (list funding county):
- ☐ Community Living Waiver (list funding county):
- ☐ Base Funds (list funding county):
- ☐ Private Pay
- ☐ Residential Contract
- ☐ Health Insurance (next section required)

Private Health Insurance

- ☐ UPMC Partner Network
- ☐ UPMC Premier Network
- ☐ UPMC My Care Advantage HMO
- ☐ UPMC My Care Advantage PPO
- ☐ UPMC for Kids (CHIP)
- ☐ UPMC For You **Allegheny County** (Medical Assistance)

Insurance Member ID:

Social Security #:

Current or Past Mental Health Diagnoses:

Currently receiving treatment? If so, with who?

Information on Referral Source ***(person making the referral)***

Date:		
Name (First):	**Name** (Last):	
Relationship/Entity:		
Address:		
City:	**State**:	**Zip Code**:
Phone:	**Email**:	

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County of Residence:	**SC Name:**
SC Phone Number:	**SC Email:**

Reason for Referral/Describe Problematic Behaviors or Symptoms:

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