**PEER SUPPORT SERVICES**

**Instructions**: This form **MUST** be completed and signed by a Physician, Psychologist, PA or CRNP.

Referrals will not be processed until this letter is completed and returned.

If you have questions or need assistance, please contact our office.

**RECOMMENDATION LETTER**

**Peer Support Services are specialized therapeutic interactions conducted by trained professionals who are self-identified as current or former participants in behavioral health services. Peer Support Services are self-directed and person centered with a recovery focus. They facilitate the development of recovery skills. Services are multi-faceted and include, but are not limited to, individual advocacy, crisis management support, and skills training. Services can occur within the home setting, or out exploring resources within the local community.**

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_recommend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(PRINT NAME) (PRINT NAME)**

**for Peer Support Services at Aurora Services.**

**MH Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ICD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medically necessary criteria for recommendation:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate evidence of functional impairments: (THIS SECTION MUST BE COMPLETED)**

**Please circle: Moderate Severe**

|  |  |
| --- | --- |
| **LIVING** |  |
| **LEARNING** |  |
| **WORKING** |  |
| **SOCIALIZATION** |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF REFERRING PERSON DATE**

*\*By signing I am recommending the above named individual for Peer Support Services\**

**PLEASE CHECK TITLE: \_\_\_\_ PHYSICIAN \_\_\_\_ PSYCHIATRIST \_\_\_\_ PSYCHOLOGIST**

**\_\_\_\_ PHYSICIAN ASSISTANT \_\_\_\_ CERTIFIED NURSE PRACTITIONER**