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
☐ Functional Behavior Assessment (FBA)
☐ Sexual Consent Screening

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

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Funding Source (list all that apply): *Please note all funding sources must be verified.*

☐ ODP Consolidated Waiver (list funding county):
☐ Residential Contract
☐ Community Living Waiver (list funding county):
☐ Base Funds (list funding county):
☐ Private Pay

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

Date:		
Name (First):	**Name** (Last):	
Relationship/Entity:		
Address:		
City:	**State**:	**Zip Code**:
Phone:	**Email**:	
County of Residence:	**SC Name:**	
SC Phone Number:	**SC Email:**	

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Reason for Referral/Describe Problematic Behaviors or Symptoms:

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