



Phone: (717)835-2270

Fax: (717)835-2299

South Central Health Care Quality Unit Referral Request

Process for Referral to the HCQU:

1. The representative from the provider agency, county program, family or other support services will complete a referral request for HCQU services.
2. The Supports Coordinator or HCQU liaison will be informed of the referral by the requestor or HCQU nurse.
3. The referral form will be given to the HCQU nurse or faxed to the HCQU at (717) 835-2299

Supports Coordinator:

Name: _____
 Phone: _____
 Email: _____

Contact Person:

Name: _____
 Phone: _____
 Email: _____
 Relationship to Individual: _____

Provider Information:

County/Joinder: _____
 Provider Name: _____
 Address for the appointment: _____

Supported Individual (if applicable):

Name: _____
 Age: _____
 Diagnoses: _____

REASON FOR REFERRAL:

- Consumer Data Collection (CDC) (Medical and Behavioral Assessment) Training
 Pharmacy Review Psychiatric Review Fall Risk Assessment Bio-Graphical Timeline

Completed by: _____ Date/Time: _____

County AE Signature: _____ Date: _____

The following information will be completed by HCQU:

Date Received by HCQU: _____ HCQU Director: _____

Staff Assigned: _____ Date: _____

Scheduled Date and Time: _____ SC Notified: Yes _____ No _____