MEMBERSHIP REFERRAL

Howard Levin Clubhouse
A Program of
Jewish Residential Services

DIRECTIONS: Please return this completed form, along with a **Psychiatric Evaluation (Axis I-V) signed by a psychiatrist or MD, to: Howard Levin Clubhouse, 2621 Murray Avenue, Pittsburgh PA 15217. You may also FAX this form to (412) 422-9519.**

Date of referral: _____

Name: _____ Birth Date: ____ / ____ / ____

Address: _____ City, State, Zip _____

Home Phone: _____ Cell Phone: _____ SSN: _____

EMERGENCY CONTACT Family member, guardian, or significant other to be notified in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City, State, Zip: _____ Cell Phone: _____

Reason for referral: _____

_____

A. HEALTH AND SOCIAL SERVICE INFORMATION

	Name	Location	Phone
Psychiatrist			
Therapist			
Service Coordination			
Medical Doctor			

List any medical problems or physical disabilities, especially those that would limit physical activities or those that require assistive technology or an interpreter:

_____

_____

Is the applicant currently on parole or probation? If so, explain: _____

_____

B. SOURCE OF INCOME

☐ SSI ☐ SSDI ☐ VA ☐ Job ☐ Other: _____

Does the member have a representative payee? ☐ No ☐ Yes If yes, please specify: _____

C. HEALTH INSURANCE

Medical Assistance ID#: _____ Medical Assistance Provider: _____

Medicare #: _____ Medicare Provider: _____

Private Health Insurance: _____ ID#: _____

MEMBERSHIP REFERRAL	 **Howard Levin Clubhouse** A Program of Jewish Residential Services

D. CLINICAL INFORMATION

1. DIAGNOSIS

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current: _____ Highest in Past Year: _____

2. INPATIENT HOSPITALIZATION HISTORY

Facility/Address	From	To

Has the applicant ever exhibited or made threats of harm to self or others? If so, explain.

_____

_____

3. OUTPATIENT TREATMENT HISTORY

Facility/Address	From	To

4. CURRENT MEDICATIONS

Medication	Dosage	Frequency	Medication	Dosage	Frequency

MEMBERSHIP REFERRAL	 **Howard Levin Clubhouse** A Program of Jewish Residential Services

E. STRENGTHS, SUPPORTS, AND NEEDS

For each area, please rate on a scale of 0 to 5 the level of assistance the applicant needs or desires. Please identify the change that the applicant wishes to make in that domain, if any. Also list their strengths in each of the domains.

0- Needs no assistance 1- Needs minimal assistance 2- Needs some assistance
3- Needs moderate assistance 4- Needs substantial assistance 5- Needs extensive assistance

Scale	Domain	Describe strengths, limitations and goals in each domain
_____	Living:	_____
_____	Learning:	_____
_____	Working:	_____
_____	Socializing:	_____

F. REFERRED BY (Please print):

Name: _____ Title: _____

Agency: _____ Phone: _____

Signature: _____ Email: _____

G. APPLICANT'S SIGNATURE:

My signature indicates that this referral has been discussed with me, and I am in agreement with it.

Applicant's Signature: _____ Date: _____

REFERRAL CHECKLIST – All applicants will need to provide the following items:

☐ Completed referral form (this form)	☐ Psychiatric evaluation with an Axis I-V diagnosis signed by an MD or psychiatrist
☐ Signed Release of Information form	☐ Signed recommendation from MD or psychiatrist (see page 4)

MEMBERSHIP REFERRAL	**Howard Levin Clubhouse** A Program of Jewish Residential Services

TO: Referral Coordinator, Howard Levin Clubhouse
FROM: _____
DATE: _____
RE: Recommendation for Referral to Howard Levin Clubhouse

This memo serves as my formal recommendation for _____
(print applicant's name)
to receive Psychiatric Rehabilitation services at the Howard Levin Clubhouse.

_____ _____
Signature Date

_____ _____
Printed Name Title

Note: In accordance with Pennsylvania guidelines and regulations for Psychiatric Rehabilitation, this recommendation must be signed by a "physician or licensed practitioner of the healing arts acting within the scope of professional practice." The referral cannot be considered to be complete without this signed recommendation.

Please contact the Clubhouse Director at (412) 422-1850 for any questions regarding this referral form.

CLUBHOUSE USE ONLY

☐ Completed referral form	☐ Psychiatric evaluation with an Axis I-V diagnosis signed by an MD or psychiatrist
☐ Signed Release of Information form	☐ Signed recommendation from MD or psychiatrist

Referral approved by:

_____ _____
Signature Date