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

Directions: Please return this completed form, along with a **PSYCHIATRIC EVALUATION** (ICD 10 Codes) signed by **Psychiatrist or PCP** to: **Sally and Howard Levin Clubhouse 2609 Murray Avenue, Suite #101 Pittsburgh, PA 15217** or fax to (412-422-9519) or email to jherbick@jrspgh.org

PERSONAL INFORMATION

Date of referral:_____

Name:_____

Address:_____

City:_____ State: _____ Zip: _____ County: _____

Home Phone:_____ Cell Phone: _____Email: _____

Social Security Number: _____

EMERGENCY CONTACT:_____Relationship:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

REASON FOR REFERRAL_____

_____

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

HEALTH PROVIDERS

Psychiatrist: _____ Phone:_____

Therapist: _____ Phone:_____

Service Coord:_____ Phone:_____

PCP: _____ Phone:_____

HEALTH CONDITIONS

Please list medical problems or disabilities, especially those requiring reasonable accommodations/dietary modification:

_____

_____

SOURCE OF INCOME

SSI SSDI VA Job Other:_____

Does applicant have a representative payee? NO YES, specify:_____

INSURANCE INFORMATION

Medical Assistance ID#_____ Medical Assistance Provider:_____

Medicare ID# _____ Medicare Provider: _____

Private Insurance ID#_____ Private Insurance Provider:_____

MEMBERSHIP REFERRAL

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Services

CLINICAL INFORMATION

Diagnosis: ICD 10 Codes

_____
_____
_____

MOST RECENT INPATIENT HOSPITALIZATIONS

Facility	From	To

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

_____
_____

MOST RECENT OUTPATIENT HOSPITALIZATIONS

Facility	From	To

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency

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STRENGTHS, SUPPORTS, AND NEEDS ***MUST complete this section fully***

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. ***Please note Psychiatric Rehabilitation regulations state that because of mental illness, the individual is considered to have a moderate to severe functional impairment that interferes with or limits performance in at least one of the following 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**	_____
		_____

REFERRED BY (please print)

Name:_____ Title:_____

Agency:_____Phone:_____

Signature:_____ Email:_____

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 ICD 10 code diagnosis signed by PCP or Psychiatrist
	Signed release of information form		Signed recommendation from PCP or Psychiatrist (page 4)

MEMBERSHIP REFERRAL

Sally and Howard Levin Clubhouse
A Program of
Jewish Residential Services

DATE:_____

TO: Referral Coordinator, Sally and Howard Levin Clubhouse

FROM: _____

RE: Recommendation for Referral to Sally and Howard Levin Clubhouse

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

_____ _____
Printed Name Date

_____ _____
Signature Date

*****PLEASE 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 (LPCA) acting within the scope of professional practice." Persons who are considered to be LPHA include only the following: **Medical Doctors (MD), Doctors of Osteopathic Medicine (DO), Certified Registered Nurse Practitioners (CRNP) or Physician Assistants (PA).**

The referral cannot be considered complete without this signed recommendation.

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

CLUBHOUSE USE ONLY

	Completed referral form (this form)		Psychiatric evaluation with ICD 10 code diagnosis signed by PCP or Psychiatrist
	Signed release of information form		Signed recommendation from PCP or Psychiatrist (page 4)

Referral approved by:

_____ _____
Signature Date