MEMBERSHIP REFERRAL

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 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: _____ SSN# _____

Name: _____ Birth Date: _____/_____/_____

Address: _____ City, State, Zip_____

Home Phone:_____ Cell Phone: _____

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: _____

_____

HEALTH AND SOCIAL SERVICE INFORMATION

Psychiatrist Name:_____ Phone: _____

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

	Name	Address	Phone
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, please explain. _____

_____

SOURCE OF INCOME Please circle one

SSI SSDI VA Job Other: _____

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

HEALTH INSURANCE

Medical Assistance ID#_____ Medical Assistance Provider _____

Medicare #_____ Medicare Provider:_____

Private Health Insurance:_____

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CLINICAL INFORMATION

1. DIAGNOSIS: ICD 10 CODES

_____

_____

_____

2. INPATIENT HOSPITALIZATION HISTORY

Facility/Address	To	From

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

_____

_____

3. OUTPATIENT HOSPITALIZATION HISTORY

Facility/Address	To	From

4. CURRENT MEDICATIONS

Medication	Dosage	Frequency	Medication	Dosage	Frequency

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. Please note that the Psychiatric Rehabilitation regulations suggest that scores of "moderate assistance" (3) or above in at least one domain qualify an individual for the service.

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. **REFFERED BY (Please print):**

Name: _____ Title: _____

Agency: _____Phone: _____

Signature: _____ Email: _____

G. APPLICANTS 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 ICD 10 code diagnosis signed by an MD or psychiatrist.
Signed Release of Information form	Signed recommendation from MD or psychiatrist (see page 4)

MEMBERSHIP REFERRAL

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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 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 (LPHA) acting within the scope of professional practice." Persons who are considered to be an LPHA currently only include Medical Doctors (MD), Certified Registered Nurse Practitioners (CRNP), or Physician's Assistants (PA).

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 ICD 10 code diagnosis signed by an MD or psychiatrist.
Signed Release of Information form	Signed recommendation from MD or psychiatrist

Referral approved by:

_____ _____
Signature Date