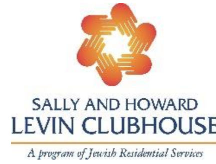
MEMBERSHIP REFERRAL	 **Sally and Howard Levin Clubhouse** A Program of Jewish Residential Services

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: ______________________________________

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:____

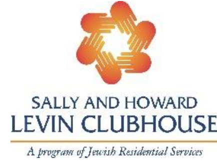
INSURANCE INFORMATION

Medical Assistance ID#_______________________________ Medical Assistance Provider:______________________________

Medicare ID# _____________________________________ Medicare Provider: ______________________________________

Private Insurance ID#_________________________________ Private Insurance Provider:______________________________

Applicant Name:

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

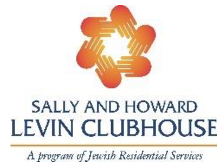
____
____

MOST RECENT OUTPATIENT HOSPITALIZATIONS

Facility	From	To

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency

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

STRENGTHS, SUPPORTS, AND NEEDS ***MUST complete this section in full***

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: *(if additional space is needed, please add on to the back of this page, or attach an additional page.)*
	Living	______________________ ______________________
	Learning	______________________ ______________________
	Working	______________________ ______________________
	Socializing	______________________ ______________________

REFERRED BY (please print)

Name:______________________ Title:______________________

Agency:______________________ Phone:______________________

Signature:______________________ Email:______________________

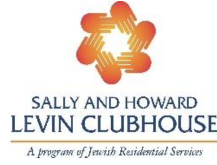
APPLICANT'S SIGNATURE

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	