MEMBERSHIP REFERRAL
(Updated November 2022)

Sally and Howard Levin Clubhouse
A Program of

JRS is now
The branch
Taking inclusion to new heights.

Directions: Please return this completed form, along with the referral found on page 4 signed by a **MD, DO, CRNP or PA**, to Mail: **Sally and Howard Levin Clubhouse 2609 Murray Avenue, Suite #101 Pittsburgh, PA 15217,**
Fax:(412)-422-9519 /or/ **Email (*preferred*)**: referrals@thebranchpgh.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:______________________________

CLINICAL INFORMATION

ICD 10 CODE	DIAGNOSIS

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 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 agree with it.

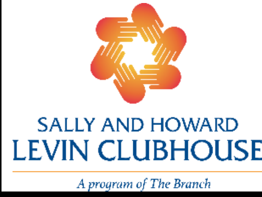
Applicant's Signature:_____________________________ Date: ___________________

REFERRAL CHECKLIST- All applicants will need to provide the following items to be processed in a timely and efficient manner. Please use this checklist to ensure all items are present:

- ☐ **Completed referral form (this form)**
- ☐ **Signed release of information form**
- ☐ **Signed recommendation from PCP or Psychiatrist (page 4)**

MEMBERSHIP REFERRAL

(Updated November 2022)



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<u>The referral cannot be considered without this signed recommendation.</u>

DATE:____________

TO: **<u>Referral Coordinator, Sally and Howard Levin Clubhouse</u>**

FROM: ____

RE: **<u>Recommendation for Referral to Sally and Howard Levin Clubhouse</u>**

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

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

<u>CLUBHOUSE USE ONLY</u>

☐	Completed referral form (this form)		
☐	Signed release of information form	☐	Signed recommendation from PCP or Psychiatrist (page 4)

Referral approved by:	
Signature	**Date**