MEMBERSHIP REFERRAL

(Updated January 2024)

SALLY AND HOWARD LEVIN CLUBHOUSE
A program of The Branch

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A Program of
JRS is now The branch
Taking inclusion to new heights.

Directions: Please return this completed form signed by a **MD, DO, CRNP, PA, MSW, LPC, CRC**, or any other Mastered Level Mental Health Professional (****Please Note***: **Page #4 must be signed by a MD/DO/CRNP/PA per OMHSAS regulations**) 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_____

_____

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:_____

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CLINICAL INFORMATION

ICD 10 CODE	DIAGNOSIS

ANY INPATIENT PSYCHIATRIC HOSPITALIZATIONS IN THE PAST THREE (3) YEARS? ❑ YES ❑ NO

If YES, please list hospitalizations below:

Facility	From	To

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

_____

_____

ANY OUTPATIENT OR PARTIAL HOSPITALIZATIONS IN THE PAST THREE (3) YEARS | ❑ N/A

Facility	From	To

ANY ARRESTS OR INCARCERATIONS IN THE PAST THREE (3) YEARS? ❑ YES ❑ NO

If YES, please provide details below:

Date(s)	Details of Arrest/Incarceration (Example: Charges, Probation Information, etc.)	Facility (example: Allegheny Co Jail)
	_____ _____	
	_____ _____	

Is the applicant currently on parole or probation? If so, please explain above under "details".

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency

If more space is needed for answers, please detail them on a separate sheet, and attach it to the referral.

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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)**

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The referral cannot be considered without this signed recommendation.

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 (*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.

CLUBHOUSE USE ONLY

☐	**Completed referral form (this form)**		
☐	**Signed release of information form**	☐	**Signed recommendation from PCP or Psychiatrist (page 4)**
Referral approved by:			
Signature		**Date**	