HOPE SPRINGS CLUBHOUSE REFERRAL FORM

Please fax the completed referral form to 610-375-3595
40 Kenhorst Blvd., Reading, PA 19607
Telephone: 484-650-0198
Psych Eval is not required, but encouraged

Referring Provider Agency:	
Name:	
Phone:	

Name:	**DOB:**
Social Security Number:	**MA#:**
Home Address:	
Phone:	**Alt Phone:**

Diagnosis: Must have the presence or history of a serious mental illness - schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder, borderline personality disorder, anxiety disorders, post-traumatic stress disorder; excluding primary diagnosis of Intellectual Disability, Autism, substance abuse, and dementia unless they co-exist with a psychiatric disorder.

Behavioral Health:
Medical Conditions/Any Special Needs:

Primary Care Provider Name:	**Phone:**
Psychiatrist Name:	**Phone:**
Does individual receive other psychiatric rehabilitation services (Mobile Psych [Holcomb], or Assertive Community Treatment [ACT])? ☐ **Yes** ☐ **No** **Name:** **Phone:**	
Caseworker Name:	**Phone:**

Is individual on probation or parole? ☐ **Yes** ☐ **No** **Explain:**	**Probation/Parole Officer Name:** **Phone:**
Does the individual have any restrictions on interacting with minors? ☐**Yes** ☐**No**	

Reason for Referral/Goals: (In the domains of Living/Learning/Working/Social)

Referred Individual' Signature: ____**Date:** ____________

LPHA Print & Sign: ____ **Date:** ____________________

LPHA - physician, physician's assistant, certified registered nurse practitioner, licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor or psychologist.