Mosaic House Clubhouse
Referral Form

Please fax or mail the completed form:
Mosaic House
525 Franklin Street
Reading, PA 19602
Phone: 610-375-7840 Fax: 610-375-7845

Referring Provider	
Name:	
Contact Number:	

Psych Eval is not required, but encouraged

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	
Behavioral Health	
Medical Conditions/ Physical Health Issues	

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:**

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.

Revised: 1/30/25