WESTMORELAND PSYCHIATRIC REHABILITATION
REFERRAL FORM

1037 Compass Circle, Suite 102
Greensburg, PA 15601
PHONE: (724) 834-5774
FAX: (724) 834- 5399

REFERRAL DATE:_____

CLIENT NAME:_____ **SS #**_____

ADDRESS:_____

_____

TELEPHONE NUMBER:_____**D.O.B.**_____

CASE MANAGER: TCM ___ **ACM**___ **NAME:** _____

PSYCHIATRIC INFORMATION:

PSYCHIATRIC DIAGNOSIS: DSM#:_____

Admission Criteria:
Schizophrenia ___ **Major Mood Disorder** ___ **Psychotic Disorder NOS** ___
Schizoaffective Disorder ___ **Borderline Personality Disorder** ___
Other mental health disorders must be reviewed.

MENTAL HEALTH TREATMENT FACILITY: _____

PSYCHIATRIST: _____

THERAPIST: _____

OUTPATIENT TREATMENT FACILITY: _____

REASON FOR REFERRAL:

_____

_____

_____

COMMUNITY SUPPORT SYSTEMS:

Housing Supports:

Threshold ☐ Passavant Memorial Homes ☐ Pathways CRR ☐ Pathways Crisis Res ☐
LTSR ☐ Ilgenfritz ☐ Leah's Personal Care ☐ Other: _____

Recreational/Educational:

West Place ☐ Step Up Drop In ☐ Guardian Angel ☐ First Link Drop In ☐
Paula Teacher ☐ Other _____

Vocational:

New Beginnings Clubhouse ☐ RCW ☐ OVR ☐ Career Link ☐ ARC ☐
Other: _____

Substance Abuse:

MISA ☐ CSAS ☐ WHO ☐ Gateway: ☐ Other: ☐

OTHER SERVICES :

_____

_____

TRANSPORTATION: ☐ DRIVER ☐ NEEDS TRANSPORTATION
POSSIBLE BARRIERS:

On Probation ☐ D & A Issues ☐ Seizures ☐ Mobility ☐ Hearing ☐
Speech ☐ Language ☐ Sight ☐ Wheelchair ☐ Diabetic ☐ Reading ☐

Other: _____

GOALS CONSUMER WOULD LIKE TO ACHIEVE:

_____

_____

_____

_____

REFERRAL SUBMITTED BY:_____