Threshold, Inc.
A COMMUNITY RESIDENTIAL REHABILITATION SERVICE
111 Tridico Way, Greensburg, PA 15601
Phone: (724) 837-9348 Email: Threshold123@comcast.net

REFERRAL FORM

Client's Name _____

Maiden Name Aliases _____

Legal Address

Phone# _____

Referred by _____

Agency _____

Birthdate _____ Sex _____ Ht. _____ Wt. _____

Education Completed _____

Religion _____

Occupation/Profession _____

Marital Status _____ No. Children _____

Income (Source and Amount Monthly):

Gross earned ..... $ _____

SSD..... $ _____

SSI ..... $ _____

Pension..... $ _____

Other..... $ _____

Medical Insurance _____

Is Client facing any legal charges?

Yes _____ No _____ If yes, describe:

Is Client on Probation? Yes _____ No _____

History of suicidal or homicidal tendencies or behavior?

Yes _____ No _____ If yes, describe:

History of alcohol or drug abuse? Yes _____ No _____

If yes, describe:

History of fire setting or arson? Yes _____ No _____

If yes, describe:

Social Security # _____

Level or Urgency for Placement:

Within 30 days _____ Within 90 days _____

Over 90 days _____

History of In-Patient Care and Dates:

Facility	From	To

Current Medication:

Type	Amount	Frequency

Is client able to manage own medication?

Yes _____ No _____

List any health care or medical problems:

List any physical problems or special diets:

Has client had any history of seizures? Yes ___ No ___

a. Diagnosis and Description of seizures:

b. Frequency of seizures: _____

c. When last seizure occurred: Anto _____

REFERRAL FORM

Why is CRR placement preferred at this time?

Family members/emergency contact or significant others who can provide support for referral:

Name _____ Relationship _____

Address _____

Phone _____

Name _____ Relationship _____

Address _____

Phone _____

The following material is needed before referral can be processed:

I. MEDICAL INFORMATION

A. Medical History which includes a review of health history (including immunizations); drug and/or alcohol history; physical disabilities or history of seizures, including complete description of seizures.

B. Report of completed Threshold, Inc. Physical Examination Form current within the last six months, signed by a licensed physician. Recommendations should be made for follow-up so client can be helped to maintain ongoing health care. Recommendations pertaining to medication and limitations of the client's activities or diet should also be made.

II. SUMMARY OF CURRENT FUNCTIONING

A. Emphasize circumstances leading to current problems and rehabilitation goals; include treatment and service plan.

III. BACKGROUND MATERIAL

A. Complete Social History.

B. Psychiatric assessment and evaluation, including current diagnosis, signed by a licensed physician, and statement regarding client's capability for self-preservation with the last year.

C. Any available vocational and/or educational material.