Chart Number: _____

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

Enhanced Independent Supportive Housing Program Referral Form

Date of Referral: _____ Referred By: _____

Agency: _____

General Information

Consumer Name: _____ Social Security #: _____

Maiden Name/Aliases: _____

Current Address:

Phone Number: _____

Birthdate: _____ Sex: _____ Height: _____ Weight: _____

Education Completed: _____ Religion: _____

Marital Status: _____ No. of Children: _____

Financial Information

Please list all sources and amount

Source	Amount	Frequency

Total Monthly Income: $ 0.00 _____

Chart Number: _____

Independent SH Referral

Is Consumer his/her own payee? Yes _____ No _____

If no, please list the Payee information below:

Name: _____ Phone Number: _____

Agency/Address:

Criminal/Legal Information

Does Consumer have any past or pending criminal/legal charges? Yes _____ No _____

If yes, please describe:

Is Consumer currently on probation? Yes _____ No _____

If yes, please describe:

History of alcohol or drug abuse? Yes _____ No _____

If yes, please describe:

Medical Information

Medical Insurance: _____ Policy Number: _____

PCP: _____ Phone Number: _____

Please list all Specialists that the Consumer uses:

Name	Phone Number	Specialty

Does the Consumer smoke: Yes _____ No _____ If yes, how much per day? _____

Does the Consumer drink coffee/caffeinated beverages? Yes _____ No _____

If yes, how many servings per day? _____

Chart Number: _____

Independent SH Referral

List any allergies to food, medicine, etc.:

Please list any Health Care or Medical Problems:

Please list any Physical Problems or special diets:

Psychiatric Information

History of Inpatient care and dates

Facility	Date Admitted	Date Discharged

History of suicidal or homicidal tendencies or behavior? Yes _____ No _____

If yes, please describe:

Outpatient Psychiatrist: _____

Address:

Phone Number: _____

Independent SH Referral

Current Medications

Please list all medications:

Drug Name	Dosage	Times Taken	For What Condition

Is Consumer able to manage own medications? Yes _____ No _____

Contact Information

Parent/Guardians:

Father's Name: _____ Phone Number: _____

Address: _____

Mother's Name: _____ Phone Number: _____

Address: _____

List any additional family members, treatment team, friends, or any supports to be involved with treatment planning:

Name: _____ Phone Number: _____

Address: _____

Relationship: _____

Name: _____ Phone Number: _____

Address: _____

Relationship: _____

Chart Number: _____

Independent SH Referral

Name: _____ Phone Number: _____

Address: _____

Relationship: _____

Name: _____ Phone Number: _____

Address: _____

Relationship: _____

Name: _____ Phone Number: _____

Address: _____

Relationship: _____

Who should be contacted in case of emergency:

Name: _____ Phone Number: _____

Address: _____

Relationship: _____

The following material is needed before referral can be processed:

I. MEDICAL INFORMATION

A. Current Physical within the last 6 months, signed by a licensed physician.

B. Current TB test within the last 6 months.

II. PSYCHIATRIC INFORMATION

A. Complete Social history.

B. Comprehensive Psychiatric Assessment and Evaluation, including current diagnosis signed by a licensed physician.

C. Current Treatment Plan and Revew.