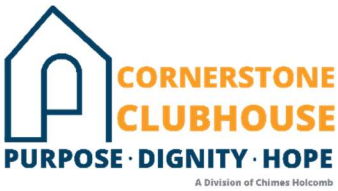

1041 W. Bridge St. Suite 10
Phoenixville, PA 19460
Phone: 610-935-2290

REFERRAL FORM

Return completed form to: cornerstoneclubhousepa@gmail.com OR Fax: 610-363-1222
PLEASE INCLUDE: Insurance card copy ☐ Medication Sheet ☐ Psychiatric Evaluation ☐

Please complete all items legibly. Use "None" or not applicable "N/A" as needed.

Applicant Name _____ BSU# _____
Phone _____ Social Security # _____
Address _____ City _____
State, Zip Code _____ Birth Date _____
Emergency Contact _____ Phone _____
Address _____

Functional Assessment & Reason for Referral:

1. Vocational
Assistance/Skills/Supports
Desired _____
2. Educational
Assistance/Skills/Supports
Desired _____
3. Living
Assistance/Skills/Support
Desired _____
4. Wellness/Manage Illness
Assistance/Skills/Support
Desired _____
5. Social
Assistance/Skills/Support
Desired _____

Means of Transportation _____

Source of Income: Public Assistance ☐ SSI ☐ SSDI ☐ VA ☐ Job ☐ Other _____

Health Insurance:
MA Access # _____ MA HMO _____
Medicare _____ Medicare HMO _____

Behavioral Healthcare Information:

DSM Diagnosis/Code # _____

DSM Diagnosis/Code # _____

Medical conditions, allergies, other disabilities _____

Current Substance Usage:

Type _____ Frequency _____

Treatment _____ 12-Step Meetings? Yes ☐ No ☐

Length of sobriety _____

Current Treatment & Services:

Type	**Primary Contact**	**Phone**
Primary Care Physician	_____	_____
Psychiatrist	_____	_____
Therapist	_____	_____
Case Manager	_____	_____
_____	_____	_____

Outpatient Commitment: Yes ☐ No ☐ If yes, dates _____

Medications: _____

Additional Behavioral Information (give a brief explanation):

Presence of significant harm to self, others, property, or unusual behaviors? (When?)

_____

Incidences of violence, arrests, prison terms, fire setting, fire safety? (When?)

_____

Current legal involvement (DUI, custody, parole, etc.)

_____

Signature of Applicant _____ **Date** _____

This referral must be signed by a Licensed Practitioner of the Healing Arts

Circle the Pennsylvania license: Physician Physician's Assistant Certified Registered Nurse Practitioner Psychologist

Signature of Licensed Health Professional _____

Print Name _____

Address _____ Phone _____