FOR OFFICE USE ONLY

DATE RECEIVED______________________

DATE INTERVIEWED___________________

ADMISSION DATE_____________________

Inquiries may be directed to our intake coordinator at 610-592-5744

Please fax all referrals to our intake office at 267-477-1071

****NOTE: HOPE ACADEMY REFERRALS REQUIRE A SIGNATURE FROM A PSYCHIATRIST TO VERIFY DIAGNOSIS AND COMPLETED RECOMMENDATION FOR PSYCHIATRIC REHABILITATION SERVICES.**

Please type or print. For referral acceptance, all sections MUST be completed. Note "N/A" or "Unknown" where necessary.
Has a consent form for release of information to Hedwig House been signed? ☐ YES ☐ NO

NAME
FIRST: __________________________ MI: ______ LAST: ___________________________ DATE OF REFERRAL: ____________________

ADDRESS: ____ SSN: __________________________

MHX#: _______________________________ DATE OF BIRTH: ____________________ CURRENT AGE: ________________

PHONE: DAY: (________)_________________________________ EVENING: (________)________________________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ WIDOWED SEX: ☐ M ☐ F

RACE: ☐ WHITE ☐ BLACK /AFRICAN AMERICAN ☐ HISPANIC/LATINO ☐ ASIAN ☐ OTHER________________

HAS APPLICANT EVER RECEIVED SERVICES FROM HEDWIG HOUSE? ☐ YES ☐ NO

IF YES, WHERE & WHEN? ____

REFERRAL INFORMATION

REFERRING AGENCY: ____ PHONE: (________)__________________________

ADDRESS: ____

NAME & TITLE OF PERSON MAKING REFERRAL: ____

PHONE: (________)________________________ EXT: ______ E-MAIL: ____

REASON FOR REFERRAL:

☐ **VOCATIONAL REHABILITATION** (EMPLOYMENT GOALS) ☐ **EDUCATIONAL** (EDUCATIONAL GOALS)

☐ **SELF MAINTENANCE – LIVING** (HOUSING GOALS) ☐ **SOCIAL** (SOCIAL GOALS)

COMMENTS: ____

____

____

PSYCHIATRIC/MEDICAL HISTORY

PRIMARY DIAGNOSIS (AXIS I): ______________________________ F# __________

SECONDARY DIAGNOSIS (AXIS II): ______________________________ F# __________

GENERAL MEDICAL STATUS (AXIS III): ______________________________

____

AXIS IV: ______________________________

AXIS V: ______________________________

SPECIAL PSYCHIATRIC NEEDS OR CAUTIONS (SUICIDE, VIOLENCE, SELF-MUTILATION, BEHAVIORAL):

____

DRUG & ALCOHOL HISTORY: ______________________________

____

HOPE ACADEMY REQUIREMENT:

PSYCHIATRIST SIGNATURE:______________________________ DATE: __________

SUPPORTS

THERAPIST: ____________________ PHONE: (_______)____________________ EXT:_______

RECOVERY COACH CONTACT & TITLE: ______________________________

RECOVERY COACH PHONE: (_______)____________________ EXT:_______

RECOVERY COACH EMAIL: ______________________________

CURRENT PSYCHIATRIST: ____________________ PHONE: (_______)____________________ EXT:_______

PRIMARY PHYSICIAN: ____________________ PHONE: (_______)____________________ EXT:_______

OTHER PROGRAMS & FREQUENCY OF ATTENDANCE: ______________________________

____

HOSPITALIZATION HISTORY

(HOSPITALIZATIONS WITHIN THE LAST YEAR)

PSYCHIATRIC

NAME OF HOSPITAL	DATE ADMITTED	DATE DISCHARGED	COMMITMENT TYPE

MEDICAL

NAME OF HOSPITAL	DATE ADMITTED	DATE DISCHARGED	COMMITMENT TYPE

CRIMINAL HISTORY

CRIMINAL HISTORY: ☐ YES ☐ NO IF YES, SPECIFY CHARGES AND ANY FOLLOW-UP (PROBATION, ETC.)

____

____

FINANCIAL INFORMATION

EMPLOYED: ☐ YES ☐ NO NAME OF EMPLOYER: ______________________________

OTHER INCOME (SSI, SSDI): ______________________________ AMOUNT: ____________________

BEHAVIORAL HEALTH PROVIDER NAME: ______________________________

PRIMARY HEALTH INSURANCE CARRIER: ______________________________

ACCESS CARD #: ______________________________

HAS APPLICANT EVER BEEN A PART OF THE U.S. MILITARY? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE BELOW:

____

EMERGENCY CONTACT

NAME: ______________________________ RELATIONSHIP: ____________________

ADDRESS: ______________________________

PHONE: (_______)______________________________ E-MAIL: ______________________________

ADDITIONAL INFORMATION

REFERRAL SOURCE: PLEASE COMMENT ON APPLICANT'S STRENGTHS AND AREAS FOR GROWTH

____

____

____

Signature: ______________________________ Date: ____________________

APPLICANT: WHAT ARE YOUR GOALS? HOW CAN YOU PARTNER WITH HEDWIG HOUSE TO MEET YOUR GOALS? PLEASE COMMENT ON YOUR STRENGTHS AND AREAS FOR GROWTH.

____

____

____

DO YOU HAVE A WRAP PLAN THAT YOU ARE WILLING TO SHARE WITH US? ☐ YES ☐ NO

DO YOU HAVE A PSYCHIATRIC ADVANCE DIRECTIVE THAT YOU ARE WILLING TO SHARE WITH US? ☐ YES ☐ NO

ARE THERE CULTURAL/RELIGIOUS CONCERNS THAT YOU WISH TO SHARE? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE BELOW:

____

I AM AWARE A REFERRAL IS BEING MADE TO HEDWIG HOUSE AND I AM WILLING TO PARTICIPATE IN SERVICES.

Signature: ______________________________ Date: ____________________

H.O.P.E. Academy
2506 N Broad St, STE 200, Colmar, PA 18915
Phone: 267-477-1070 Fax: 267-477-1071

Dear Licensed Practitioner of the Healing Arts,

____________________________________ is seeking enrollment in H.O.P.E. Academy, a licensed Intensive Psychiatric Rehabilitation program in Montgomery County, which serves young adults with serious and persistent mental illness. H.O.P.E. Academy supports young adults in achieving a self-determined goal in one of the four life domains: living, learning, working, or social.

Psychiatric Rehabilitation services (PRS) are recovery-oriented services offered individually or in groups which are predicated upon the principles, values, and practice standards of the Psychiatric Rehabilitation Association or other nationally-recognized PRS association. H.O.P.E. Academy offers services both individually and in a classroom setting.

Pursuant to 55 Pa. Code Chapter 5230, to be enrolled in a Psychiatric Rehabilitation program, applicants must receive a written recommendation from a Licensed Practitioner of the Healing Arts (**physician, physician's assistant, certified registered nurse practitioner, or psychologist**).

<u>Recommendation for Psychiatric Rehabilitation Services</u>

By signing below, I hereby recommend:

____ for Psychiatric Rehabilitation Services.

____ ________________________

Signature and Title/Credentials Date

____ ________________________

PRINT Name and Title/Credentials Date