Hedwig House, Inc.
Psychiatric Rehabilitation Services

Direct inquiries to our intake coordinator at 610-787-1982
Please email all referrals to our intake office at info@hedwighouse.org

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

DATE OF REFERRAL: _____ **MHX#:** _____

NAME FIRST: _____ **MI:** _____ **LAST:** _____

ADDRESS: _____

SEX: ☐ M ☐ F ☐ OTHER_____

SSN: _____ **DATE OF BIRTH:** _____ **CURRENT AGE:** _____

PHONE: DAY: (____)_____ EVENING:(____)_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ WIDOWED

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

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

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

IF YES, WHERE & WHEN? _____

REFERRAL INFORMATION

REFERRING AGEN_____ PHONE:(____)_____

ADDRESS:_____

NAME & TITLE OF PERSON MAKING REFERRAL:_____

PHONE: (____)_____ E-MAIL:_____

REASON FOR REFERRAL: (Check off all that apply)

☐ **Vocational Rehabilitation (Employment Goals)** ☐ **Self Maintenance – Living (Housing Goals)**

☐ **Educational (Educational Goals)** ☐ **Social (Social Goals)**

COMMENTS:_____

_____

_____

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SUPPORTS

THERAPIST:_____ PHONE:(____)_____

RECOVERY COACH CONTACT & TITLE:_____

RECOVERY COACH PHONE:(____)_____EMAIL:_____

PSYCHIATRIST: _____ PHONE: (____)_____EXT:____

PRIMARY PHYSICIAN: _____ PHONE:(____)_____

OTHER PROGRAMS & FREQUENCY OF ATTENDANCE:_____

_____

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:

_____

SPECIAL MEDICAL NEEDS OR CAUTIONS HEDWIG HOUSE STAFF SHOULD BE AWARE OF: (ALLERGIES, ETC.)_____

CRIMINAL HISTORY

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

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP:_____

ADDRESS:_____

PHONE: (____)_____ E-MAIL:_____

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ADDITIONAL INFORMATION

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

Referral Signature: _____ **Date:** _____

APPLICANT:

WHAT ARE YOUR GOALS? HOW CAN YOU COLLABORATE 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: _____

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

Applicant Signature: _____ **Date:** _____