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: _____

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

ADDRESS: _____

SEX: □ M □ F □ OTHER_____

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 AGENCY: _____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:_____

_____

_____

_____

Hedwig House, Inc.
Psychiatric Rehabilitation Services

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: _____

SECONDARY DIAGNOSIS:_____

GENERAL MEDICAL STATUS:_____

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:_____

Hedwig House, Inc.
Psychiatric Rehabilitation Services

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:** _____