# West Place Drop-In Center Referral Form

1037 Compass Circle Suite 102
Greensburg, PA 15601
Phone: 724-834-2727
Fax: 724-836-3688

Referral Date: _____________

**Client Information:**

First Name: _________________________ Middle Initial: ________ Last Name: ______________________

Date of Birth: ___________________ Social Security Number: __________________________

Address: ________________________________________

________________________________________

Telephone Number: _______________________________ Secondary Number:________________________

Reason for Referral:______________________________________________________________________

___________________________________________________________________________________________

**Diagnosis:**

Schizophrenia:____ Psychotic Disorder NOS: _______ Major Depressive Disorder: ________

Borderline Personality Disorder: ______ Schizoaffective Disorder: _____ Bi-Polar: ________

Other: ______________________________________

Psychiatrist: ________________________________________

Primary Care Physician: _____________________________________

Therapist: ______________________________________

Caseworker: _____________________________________________

**Insurance Information:**

Type of Insurance: __________________________________________

ID#: __________________________________

**Referral Source:**

Referred by: ________________________________ Title: _________________________________

Agency: _____________________________________ Phone: _______________________________

Email: ______________________________

___________________________________ ____________________________________ ____________

Client Signature | Referral Source Signature | Dat

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