WESTMORELAND PSYCHIATRIC REHABILITATION
REFERRAL FORM

1037 Compass Circle, Suite 102
Greensburg, PA 15601
PHONE: (724) 834-5774
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REFERRAL DATE:_____

CLIENT NAME:_____ SS #_____

ADDRESS:_____

_____

TELEPHONE NUMBER:_____D.O.B._____

CASE MANAGER: TCM ___ ACM___ NAME: _____

PSYCHIATRIC INFORMATION:

PSYCHIATRIC DIAGNOSIS: DSM#:_____

Admission Criteria:
Schizophrenia ___ Major Mood Disorder ___ Psychotic Disorder NOS ___
Schizoaffective Disorder ___ Borderline Personality Disorder ___
Other mental health disorders must be reviewed.

MENTAL HEALTH TREATMENT FACILITY: _____

PSYCHIATRIST: _____

THERAPIST: _____

OUTPATIENT TREATMENT FACILITY: _____

REASON FOR REFERRAL:

_____

_____

_____

COMMUNITY SUPPORT SYSTEMS:

Housing Supports:

Threshold ____ Passavant Memorial Homes ____ Pathways CRR ____ Pathways Crisis Res ___ LTSR ___ Ilgenfritz ___ Leah's Personal Care ___ Other: _____

Recreational/Educational:

West Place ____ Step Up Drop In ___ Guardian Angel ___ First Link Drop In ___ Paula Teacher ___ Other _____

Vocational:

New Beginnings Clubhouse ___ RCW ___ OVR ___ Career Link ___ ARC ____ Other: _____

Substance Abuse:

MISA ___ CSAS ___ WHO ___ Gateway: ____ Other: ___

OTHER SERVICES :

_____

_____

TRANSPORTATION: _____DRIVER _____NEEDS TRANSPORTATION
POSSIBLE BARRIERS:

On Probation _____ D & A Issues _____ Seizures _____ Mobility _____ Hearing ____ Speech ____ Language ____ Sight ____ Wheelchair ____ Diabetic _____ Reading _____

Other: _____

GOALS CONSUMER WOULD LIKE TO ACHIEVE:

_____

_____

_____

_____

REFERRAL SUBMITTED BY:_____