THRESHOLD SERVICES, INC.

REFERRAL FORM

Psychiatric Rehabilitation Program
1398 Lamberton Drive, Suite 3
Silver Spring, MD 20902
(301) 754-1102 FAX (301) 754-1690
www.thresholdservices.org

Date _____/_____/______

Referral to:
Outreach North ____ John Danna
Outreach South ____ Joseph Wakhanala
Renaissance ____ Esther Brunner

Referring Person and/or Agency ____Phone________________

Who should be contacted to schedule the intake assessment? ____

Client's Name ____ SS# _________-_______-__________

Address ____

____

Phone (_________) _________-_____________ D.O.B _______/_______/________ Age __________

Race _______________________________________ Sex __________

Medicare # ____ Effective Date _____________________

Medical Assistance # ____ Effective Date _____________________

Other Insurance # ____

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced

Number of Children ___________________

Housing Status: ____

Do you drive? _________________________ Do you use public transportation? _______________________

SOURCE OF INCOME

Parents ______ Spouse ______ Self ______ SSI/SSDI _____

Public Assistance ________________________________ Unemployment _______________________________

Other (Savings, Retirement, etc.) ____

TOTAL MONTHLY INCOME: $____________________________ Who is the rep payee? __________________

EDUCATION

High School ____ Diploma: Yes ____ No____

College ____ Diploma: Yes ____ No ____

Course of Study/Major: ____

Additional Education/Training: ____

____

Work History (positions, dates, whether volunteer or paid) ___________________________________

____

____

EMERGENCY CONTACTS

Name ____________________________________ Relationship ___________________________

Address ____

____

Home Phone (______) ________-__________ Work Phone (______) _________-___________

Medical Physician ______________________________________ Phone (______) _________-___________

Address ____

Psychiatric Physician _____________________________________ Phone (______) ________-___________

Address ____

Primary Therapist _______________________________________ Phone (______) ________-___________

Address ____

DIAGNOSTIC IMPRESSIONS: (Use DSM designation & number)

Axis I ________________________________

Axis II ________________________________

Axis III ________________________________

Axis IV ________________________________

Axis V - GAF ______________________________

Date or age of onset of disability ____________________________

History of psychiatric hospitalizations. Include dates, hospital (public/private/general), reasons, length of stay.

____

____

Describe behavior and/or symptoms, which indicate decompensation:

____

____

Describe history of criminal records and/or violence/aggression: ( ) N/A ________________________________

____

History of suicidal ideation: ( ) N/A ____

____

History of Substance abuse: ( ) N/A ____

____

Physical condition/disabilities: ( ) N/A (Include visual/auditory/physical/somatic) ______________________

____

Known allergies: ( ) N/A ____

Other current agency involvement (PRP, DVR, M.H.A., DOCR, Social Workers, etc.): Include names and phone numbers.

____

____

Previous Day Program(s) ( ) N/A (include reason for leaving) ______________________________________

____

What are the goals for PRP services? Why is the client being referred? (i.e. structure, socialization, employment support, medication monitoring, travel training, ADL support, case management, etc.) ________________________________

____

____

Client's strengths and interests: (please list) ____

____

Client's weaknesses: (please list) ____

____

Medications (name, dosage, and monitoring needs). ____

____

____

____

____ ________________

Referring agent's Signature Date

____ ________________

Client's Signature Date

THRESHOLD SERVICES, INC.
PHYSICAL EXAM STATEMENT

Date: ____________________________

I certify that ____ was given a physical exam and found to be in good health.

TB test results: PPD:________ negative or __________positive. If positive, chest x-ray results:____________________

____

Please list any medications that you prescribe for medical reasons:

____ _____________________________________

____ _____________________________________

____ _____________________________________

Please list any medical conditions and/or any instructions for medical care that are suggested for this person:

____

____

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Physician's Signature