HOPE SPRINGS CLUBHOUSE REFERRAL FORM

Threshold
Rehabilitation Services, Inc.

Please fax the completed referral form to 610-375-3595

40 Kenhorst Blvd., Reading, PA 19607
Telephone: 484-650-0198

Referring Provider Agency:	
Name:	
Phone:	

Name:	**DOB:**
Social Security Number:	**MA#:**
Home Address:	
Phone:	**Alt Phone:**

Diagnosis: List all diagnosis below & attach verification

Any Special Needs

Primary Care Provider Name:	**Phone:**
Psychiatrist Name:	**Phone:**
Does individual receive other psychiatric rehabilitation services (Mobile Psych [Holcomb], or Assertive Community Treatment [ACT])? ☐ **Yes** ☐ **No** **Name:** **Phone:**	
Caseworker Name:	**Phone:**

Is individual on probation or parole? ☐ **Yes** ☐ **No** **Explain:**	**Probation/Parole Officer** **Name:** **Phone:**
Does the individual have any restrictions on interacting with minors? ☐**Yes** ☐**No**	

Reason for Referral/Goals: (In the domains of Living/Learning/Working/Social)

Referred Individual' Signature: _____ Date: _____

The referral form MUST be signed by a physician, physician assistant, CRNP or licensed psychologist:

LPHA Print & Sign: _____ Date: _____