MOSAIC HOUSE

Mosaic House Clubhouse Referral Form

Threshold
Rehabilitation Services, Inc.

Please fax or mail the completed form:
Mosaic House
525 Franklin Street
Reading, PA 19602
Phone: 610-375-7840 Fax: 610-375-7845

Referring Provider	
Name:	
Contact Number:	

Please attach the most recent psych evaluation

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

Diagnosis (must have the presence or history of a serious mental illness - schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder, or borderline personality disorder)

Behavioral Health
Behavioral Health
Medical Conditions/ Physical Health Issues

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:**

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

Referred Individual' Signature: _____ **Date:** _____

LPHA Signature: _____ **Date:** _____

LPHA - physician, physician's assistant, certified registered nurse practitioner or licensed psychologist

LPHA Printed Name: _____

Revised: 03/16/18