Threshold

Rehabilitation Services, Inc.

Partial Hospitalization Program Referral Form

*Please **fax** completed form to **(610) 288-2439***

Questions? Telephone (610) 777-7691 Ext 156

Date of Referral_____Referring Agency_____
Person Making Referral_____Contact #:_____

Name:_____DOB:_____SS#:_____
HomeAddress:_____,_____,_____,__
Telephone:_____

Current Outpatient Agency/Psychiatrist:_____
Current PCP Agency/Medical Doctor:_____
Case management Agency/Case manager:_____

Current Medications: (list below OR **attach current med list**)

_____ _____
_____ _____
_____ _____
_____ _____
Allergies (if any): _____

INSURANCE: We accept CCBH and Fee for Service Medical Assistance
Plan #1: _____ Policy Number_____
Plan #2: _____ Policy Number_____

Diagnosis (psychiatric & medical, include ICD-10 code, must have the presence or history of a serious mental illness - schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder, or borderline personality disorder) ***Please attach the most recent psych evaluation***

_____

Reason for Referral/Goals:_____
_____

Is the person on probation/parole?☐Y / N☐ Explain_____
_____

Trauma History?☐Y / N☐ Explain_____
_____

Safety Risks/Special Concerns
Is the person medically stable? ☐ yes ☐ no Explain_____

Does the person have a SUD? ☐ yes ☐ no Explain_____

Can the person manage self-care independently. ☐ yes ☐ no

Is the person **willing** to attend group **at least** two days a week from 8:00am to 2:40pm? (The PHP operates five days a week) ☐ yes ☐ no