Threshold
Rehabilitation Services, Inc.

Berks HealthChoices Referral for Threshold RTF-A
Fax to Community Care at 1-866-418-0366

Date_____

Client Name: _____ DOB: _____

MA ID#: _____ SS#: _____

Current Address: _____

Current Phone #'s: _____

Who is making the referral? _____

Facility_____

Phone #: _____

Referral discussed with consumer, guardian and/or family? _____

Response: _____

Release of Information Signed for Community Care, and Threshold, if approved. Yes ☐ No ☐

All sections of this document must be thoroughly completed. Items should not be left blank - please indicate N/A where appropriate.

Current Community Provider Contact(s) Name(s) and Phone #s:

Psychiatrist: _____ Agency: _____

Phone #: _____

SC/BCM: _____ Agency: _____

Phone #: _____

Therapist: _____ Agency: _____

Phone #: _____

Rep Payee: _____ Agency: _____

Phone #: _____

Other: _____ Agency: _____

Phone #: _____

Other: _____ Agency: _____

Phone #: _____

PCP: _____ Phone #: _____

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Admission Criteria

The individual must be between the ages of 18 and 25

Include information regarding the clinical rationale for requesting RTF-A. If RTF-A is being requested as a result of a meeting, provide information regarding the type of meeting that occurred, where the meeting occurred, and the date of the meeting.

_____

_____

_____

_____

List Current Diagnosis (DSM 5/ICD 10) and Medications (All Required)

Behavioral Health: _____

_____

_____

_____

_____

Medications	Dose	Frequency	Prescribing Physician	Start Date

Identify consumer's support system, including family, friends, social, community,

List Supports and Relationship Frequency of Contact

1. _____
2. _____
3. _____

4. _____

Identify Member Strengths:

1. _____

2. _____

3. _____

4. _____

Educational/Vocational History:

☐ High School Diploma ☐ GED ☐ Post-Secondary Education

☐ Did not finish High School/ Did not complete GED, provide highest grade completed: ☐

☐ Has work history

Medical Conditions:

1. _____

2. _____

3. _____

4. _____

Activities of Daily Living: Check all that apply

☐ Independent with ADL's

☐ ADL Dependent Explain: _____

☐ Language Barrier Primary Language: _____

☐ Other Impairment/ Disability that would impact daily living or require additional assistance

Explain: _____

List Hospitalizations for mental health and substance abuse treatment in the last 2 years

Facility/Hospital	Dates	Outcome/Disposition

List Residential Treatment Facility treatment in the last 2 years

RTF	Dates	Outcome/Disposition

List Incarcerations in the last 2 years

Incarceration/Crisis Provider	Date of Encounter/Dates of Incarceration

List of Pending Court Dates and/or Criminal Charges:

Charge	Court Date (write date or Pending if unknown)	Explanation

List the services the consumer is involved with or has been referred to in the last 12 months including case management:

Type of Service #of contacts/week Date Last Used Outcome

1. _____
2. _____
3. _____
4. _____

There is evidence of current, co-existing mental illness and substance abuse/dependence.

List Substances Abused/Dependent:

	Type	Frequency	Date Last Used
1.			
2.			
3.			
4.			

History of life-threatening suicide attempts/life threatening self-harm within past two (2) years.

List Specific Behaviors:

	Method	Date	Disposition
1.			
2.			
3.			
4.			

History of impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to other within last 2 years

	Type of Impulsive/Acting Out Behavior	Type of Assault/Anger	Disposition/Outcome
1.			
2.			
3.			
4.			

Additional Information: