

NAME *Please enter consumer first, middle initial, and last name*

Today's Date:

Consumer Name: _____ Address: _____

Birth Name: _____
(Other Names) _____

Phone No: _____

Case No: _____ CASP#: _____ Social Security #: _____-_____-_____
Date of Birth: _____

Referral Information

Agency 1: _____ Agency 2: _____

Contact: _____ Work Phone: () _____ Contact: _____ Work Phone: () _____

Why is this client being referred to Peoples Oakland:

_____ Social Rehabilitation
 _____ Wellness
 _____ MISA programming
 _____ Vocational Rehabilitation

Medical History

Please identify members of this consumer's treatment team:

	Name	Agency	Phone
Psychiatrist:	_____	_____	_____
Therapist:	_____	_____	_____
Clinician:	_____	_____	_____
Resource Coord:	_____	_____	_____
ICM:	_____	_____	_____

Medical History (Con't)

Primary Disability: ____ Mental Health ____ Mental Retardation ____ Drug ____ Alcohol Approximate Date of Onset: _____

What is this consumer's level of functioning (GAF)? _____ Does this consumer have an IQ above 69? ____ Yes ____ No

What was this consumer's age at his/her first hospitalization? _____ Estimated number of lifetime admissions: _____

	Primary	Secondary		Primary
Diagnostic System:	_____	_____	DSM:,Axis III:	_____
DSM, Axis I:	_____	_____	DSM, Axis IV:	_____
DSM, Axis II:	_____	_____	DSM, V-Code:	_____

List Psychiatric hospitalizations over the last three years, starting with the most recent:

Hospital	From	To
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Decompensation) What is this consumer's usual decompensation pattern?

Medical History (Con't)

(Other Health) What other health problems, if any, does this consumer have? _____

Medication

What, if any, are this consumer's current prescription medications?

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is this consumer compliant with his/her current prescription medications? ____ Yes ____ No *(Compliance)* If not, please describe: _____

Substance Abuse

Date of onset of abuse problem: _____ Please list known substances of choice on next line: _____

If this consumer is not currently abusing substances, please indicate date of last known use: _____

Is this consumer actively involved in ____ AA? ____ NA? Please detail this consumer's current participation in any of the following programs:

	Contact Name	Agency	Phone
D/A Counselor:	_____	_____	_____
Inpatient Rehab:	_____	_____	_____
Resident Rehab:	_____	_____	_____

Substance Abuse (Con't)

(Drugs) Additional coments: _____

Housing

What is this consumer's current living arrangement?

- _____ Independent Living _____ Facility-Based 24-Hour Care _____ Criminal Detention
- _____ Supervised or Supported Living _____ No Permanent Home/Homeless _____ Other

Behavioral

If this consumer is on probation or parole, please provide:

	Name of Officer	Probation/Parole Agency	Phone
Probation:	_____	_____	_____
Parole:	_____	_____	_____

Does this consumer have a history of any of the following behaviors? If so, provide year of last incidence.

- _____ Suicide Attempt (Year _____) _____ Sexual Abuse/Assault (Year _____) _____ Compulsive Behavior [Lying, spending, etc.] (Year _____)
- _____ Homicide Attempt (Year _____) _____ Assault (Year _____) _____ Drug/Alcohol Abuse (Year _____)
- _____ Fire Setting (Year _____) _____ Theft (Year _____) _____ Other _____ (Year _____)

(Behavior) Please provide details on treatment and/or legal outcomes subsequent to any of the above behaviors: _____

Behavior (Con't)

(Legal) If this consumer is currently facing legal charges, please describe: _____

Financial Information

Please list this consumer's *monthly income* by source:

Salary/Wages	_____	SSDI	_____	VA Benefits	_____
Social Security	_____	Domiciliary Care	_____	Other (Unemployment Comp, Workers Comp, WIC, Child Support, etc.)	_____
Pension	_____	Public Assistance/AFDC	_____		
SSI	_____	Food Stamps	_____		

What is the name of this consumer's welfare caseworker? _____ Phone _____

Financial (Con't)

(Financial Problems) Describe other financial problems this consumer may be facing: _____

Vocational

OVR Counselor: _____ Phone: _____

Is this consumer able to read and write at the adult level? ____ Yes ____ No

(Impairment) How does this consumer's disability interfere with his/her ability to work: _____

Please attach any documentation (medical records, psychological or vocational test results, etc.) pertinent to this consumer's medical, social, or legal history.

The staff of Peoples Oakland thank you for your help in providing this information!

RETURN TO: Becky Flotta, Intake Coordinator
Peoples Oakland Building
3433 Bates Street
Pittsburgh, PA 15213

Phone: 412.683.7140 x236 Fax: 412.683.7138