Peoples Oakland Referral Form- Revised 2017

Contact Information

Today's Date:

Birth Name: _____ Preferred Name: _____

Address: _____

Phone Number: _____ Social Security #: _____-____-_____ Date of Birth: ___/___/_____

Referral Information

Agency: _____

Contact: _____ Phone Number: _____

Why is this person being referred to Peoples Oakland? (Check all that apply)

___ Social Rehabilitation ___ Wellness Services ___ Drug/Alcohol Rehabilitation ___ Vocational Rehabilitation

Treatment Team Information

Please identify members of this person's treatment team:

	Name	Agency	Phone
Psychiatrist:			
Therapist:			
Service Coord:			
PCP:			
Other:			

Mental Health History

Clinical Disorders (include ICD 10 code)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

Hospital	From	To

What is this person's usual decompensation pattern?

_____

_____

_____

_____

_____

Physical Health History

What physical health problems, if any, does this person have? _____

_____

_____

Medications

What, if any, are this person's current prescription medications? You may also attach an updated list of medications.

Name	Dosage	Frequency	Purpose

Is this person compliant with their current prescription medications? _____ Yes _____ No

If not, please describe: _____

_____

_____

Housing

What is this person's current living arrangement?

_____ Independent Living

_____ Supervised or Supported Living (LTSR, CRR)

_____ Group Home

_____ Facility-Based 24 Hour Care

_____ Domiciliary Care

_____ Halfway or ¾ House

_____ No Permanent Home or Homeless

_____ Shelter

_____ With Family Member

_____ Other (please describe)

If not independent living, please provide the following information:

Facility Name: _____

Staff Contact: _____

Phone Number: _____

Substance Abuse

If this person currently uses or has a history of use, please list known substance(s):_____

_____

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

Is this person currently involved in either of these supports? AA _____ NA _____

Comments regarding past D/A treatment or rehab: _____

_____

_____

Behavioral

Does this person have a history of any of the following behaviors? If so, please specify year(s) of occurrence.

_____ Suicide Attempt

_____ Self-Harm (cutting, pulling out hair, etc.)

_____ Homicide Attempt

_____ Fire Setting

_____ Theft

_____ Drug/Alcohol Abuse

_____ Compulsive Behaviors (lying, hoarding, etc.)

_____ Incarceration

_____ Victim of Sexual Abuse/Assault

_____ Perpetrator of Sexual Abuse/Assault

If yes, was the victim an adult or child? _____

If child, is this person registered on Megan's Law? _____ Yes _____ No

_____ Victim of Physical Abuse/Assault

_____ Perpetrator of Physical Abuse/Assault

Please provide details subsequent to any of the above behaviors, such as treatment or legal outcomes: _____

_____

_____

_____

If this person is on probation or parole, please provide the following information:

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

If this person is facing any legal issues, please describe: _____

_____

_____

Vocational

Is this person able to read and write at an adult level? _____Yes _____ No

Is this person currently volunteering? _____ Yes _____ No

If yes, with what organization and for how long? _____

Is this person currently employed? _____ Yes _____ No

If yes, with what company and for how long? _____

How does this person's mental illness impact their ability to work? _____

_____

_____

Financial Information

Please indicate the amount and source of person's monthly income:

_____ Salary/Wages _____ Social Security _____ VA Benefits

_____ SSI (Supplemental Security Income) _____ Public Assistance (TANF) _____ Pension

_____ SSDI (Social Security Disability Insurance) _____ Food Stamps (SNAP) _____ Other

Describe any financial problems this person may be facing:_____

_____

_____

Please attach any documentation (medical records, psychological evaluations, etc.) pertinent to this consumer's medical, social, or legal history. The staff of Peoples Oakland thanks you for your help in providing this information.

RETURN TO

Jennie Pabst, Intake Coordinator

Peoples Oakland

3433 Bates Street

Pittsburgh, PA 15213

Phone: (412) 683-7140 x249

Fax: (412) 683-7138

Email: jenniep@peoplesoakland.org