Hedwig House, Inc.
Psychiatric Rehabilitation Services

FOR OFFICE USE ONLY
DATE RECEIVED_____
DATE INTERVIEWED_____
ADMISSION DATE_____

Inquiries may be directed to our intake coordinator at 610-787-1982

Please fax all referrals to our intake office at 215-659-5755

****NOTE: HOPE ACADEMY REFERRALS REQUIRE A SIGNATURE FROM A PSYCHIATRIST TO VERIFY DIAGNOSIS AND COMPLETED RECOMMENDATION FOR PSYCHIATRIC REHABILITATION SERVICES.**

Please type or print. For referral acceptance, all sections MUST be completed. Note "N/A" or "Unknown" where necessary.
Has a consent form for release of information to Hedwig House been signed? ☐ YES ☐ NO

NAME
FIRST: _____ MI: _____ LAST: _____ DATE OF REFERRAL: _____

ADDRESS: _____ SSN: _____

MHX#: _____ DATE OF BIRTH: _____ CURRENT AGE: _____

PHONE: DAY: (_____)_____ EVENING: (_____)_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ WIDOWED SEX: ☐ M ☐ F

RACE: ☐ WHITE ☐ BLACK /AFRICAN AMERICAN ☐ HISPANIC/LATINO ☐ ASIAN ☐ OTHER_____

HAS APPLICANT EVER RECEIVED SERVICES FROM HEDWIG HOUSE? ☐ YES ☐ NO

IF YES, WHERE & WHEN? _____

REFERRAL INFORMATION

REFERRING AGENCY: _____ PHONE: (_____)_____

ADDRESS: _____

NAME & TITLE OF PERSON MAKING REFERRAL: _____

PHONE: (_____)_____ EXT: _____ E-MAIL: _____

REASON FOR REFERRAL:

☐ **VOCATIONAL REHABILITATION** (EMPLOYMENT GOALS) ☐ **EDUCATIONAL** (EDUCATIONAL GOALS)

☐ **SELF MAINTENANCE – LIVING** (HOUSING GOALS) ☐ **SOCIAL** (SOCIAL GOALS)

COMMENTS: _____

_____

_____

PSYCHIATRIC/MEDICAL HISTORY

PRIMARY DIAGNOSIS (AXIS I): _____ F# _____

SECONDARY DIAGNOSIS (AXIS II): _____ F# _____

GENERAL MEDICAL STATUS (AXIS III): _____

_____

AXIS IV: _____

AXIS V: _____

SPECIAL PSYCHIATRIC NEEDS OR CAUTIONS (SUICIDE, VIOLENCE, SELF-MUTILATION, BEHAVIORAL):

_____

DRUG & ALCOHOL HISTORY: _____

_____

HOPE ACADEMY REQUIREMENT:

PSYCHIATRIST SIGNATURE:_____ DATE: _____

SUPPORTS

THERAPIST: _____ PHONE: (_____)_____ EXT:_____

RECOVERY COACH CONTACT & TITLE: _____

RECOVERY COACH PHONE: (_____)_____ EXT:_____

RECOVERY COACH EMAIL: _____

CURRENT PSYCHIATRIST: _____ PHONE: (_____)_____ EXT:_____

PRIMARY PHYSICIAN: _____ PHONE: (_____)_____ EXT:_____

OTHER PROGRAMS & FREQUENCY OF ATTENDANCE: _____

_____

HOSPITALIZATION HISTORY

(HOSPITALIZATIONS WITHIN THE LAST YEAR)

PSYCHIATRIC

NAME OF HOSPITAL DATE ADMITTED DATE DISCHARGED COMMITMENT TYPE

_____

_____

_____

MEDICAL

NAME OF HOSPITAL DATE ADMITTED DATE DISCHARGED COMMITMENT TYPE

_____

_____

_____

CRIMINAL HISTORY

CRIMINAL HISTORY: ☐ YES ☐ NO IF YES, SPECIFY CHARGES AND ANY FOLLOW-UP (PROBATION, ETC.)

_____

_____

FINANCIAL INFORMATION

EMPLOYED: ☐ YES ☐ NO NAME OF EMPLOYER: _____

OTHER INCOME (SSI, SSDI): _____ AMOUNT: _____

BEHAVIORAL HEALTH PROVIDER NAME: _____

PRIMARY HEALTH INSURANCE CARRIER: _____

ACCESS CARD #: _____

HAS APPLICANT EVER BEEN A PART OF THE U.S. MILITARY? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE BELOW:

_____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE: (_____)_____ E-MAIL: _____

ADDITIONAL INFORMATION

REFERRAL SOURCE: PLEASE COMMENT ON APPLICANT'S STRENGTHS AND AREAS FOR GROWTH

_____

_____

_____

Signature: _____ Date: _____

APPLICANT: WHAT ARE YOUR GOALS? HOW CAN YOU PARTNER WITH HEDWIG HOUSE TO MEET YOUR GOALS? PLEASE COMMENT ON YOUR STRENGTHS AND AREAS FOR GROWTH.

_____

_____

_____

DO YOU HAVE A WRAP PLAN THAT YOU ARE WILLING TO SHARE WITH US? ☐ YES ☐ NO

DO YOU HAVE A PSYCHIATRIC ADVANCE DIRECTIVE THAT YOU ARE WILLING TO SHARE WITH US? ☐ YES ☐ NO

ARE THERE CULTURAL/RELIGIOUS CONCERNS THAT YOU WISH TO SHARE? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE BELOW:

_____

I AM AWARE A REFERRAL IS BEING MADE TO HEDWIG HOUSE AND I AM WILLING TO PARTICIPATE IN SERVICES.

Signature: _____ Date: _____

H.O.P.E. Academy
2506 N Broad St, STE 200, Colmar, PA 18915
Phone: 267-477-1070 Fax: 267-477-1071

Dear Licensed Practitioner of the Healing Arts,

_____ is seeking enrollment in H.O.P.E. Academy, a licensed Intensive Psychiatric Rehabilitation program in Montgomery County, which serves young adults with serious and persistent mental illness. H.O.P.E. Academy supports young adults in achieving a self-determined goal in one of the four life domains: living, learning, working, or social.

Psychiatric Rehabilitation services (PRS) are recovery-oriented services offered individually or in groups which are predicated upon the principles, values, and practice standards of the Psychiatric Rehabilitation Association or other nationally-recognized PRS association. H.O.P.E. Academy offers services both individually and in a classroom setting.

Pursuant to 55 Pa. Code Chapter 5230, to be enrolled in a Psychiatric Rehabilitation program, applicants must receive a written recommendation from a Licensed Practitioner of the Healing Arts (**physician, physician's assistant, certified registered nurse practitioner, or psychologist**).

Recommendation for Psychiatric Rehabilitation Services

By signing below, I hereby recommend:

_____ for Psychiatric Rehabilitation Services.

_____ _____

Signature and Title/Credentials Date

_____ _____

PRINT Name and Title/Credentials Date