



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

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: _____

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: _____