

**HOWARD LEVIN CLUBHOUSE**  
**MEMBERSHIP REFERRAL**  
 A Program of Jewish Residential Services

**2621 Murray Ave.**  
**Pittsburgh, PA 15217**  
**(412) 422-1850**

**DIRECTIONS:** Please return this completed form, along with a **Psychiatric Evaluation (DSM-IV Axis I-V)** signed by a psychiatrist or MD, to: Howard Levin Clubhouse / 2621 Murray Ave. / Pittsburgh, PA 15217 / or fax to: **412-422-9519** Date of referral \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

SSN: \_\_\_\_\_

**EMERGENCY CONTACT** Family member or guardian to be notified in case of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Reason for referral:** \_\_\_\_\_

**A. HEALTH AND SOCIAL SERVICE INFORMATION**

	Name	Location	Phone
<b>Psychiatrist</b>			
<b>Therapist</b>			
<b>Service Coordinator</b>			
<b>Medical Doctor</b>			

List any medical problems or physical disabilities, especially those that would limit physical activities or those that require assistive technology or an interpreter.

\_\_\_\_\_  
 \_\_\_\_\_

Is the member currently on parole or probation? If so, explain. \_\_\_\_\_

\_\_\_\_\_

**B. SOURCE OF INCOME**

Public Assistance    SSI    SSDI    VA    Job    Other \_\_\_\_\_

**C. HEALTH INSURANCE**

Medical Assistance ID #: \_\_\_\_\_ Medical Assistance Provider: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicare Provider: \_\_\_\_\_

Private Health Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_

**D. CLINICAL INFORMATION**

**1. DIAGNOSIS**

Axis I: \_\_\_\_\_ DSM-IV#: \_\_\_\_\_

Axis II: \_\_\_\_\_ DSM-IV#: \_\_\_\_\_

Axis III: \_\_\_\_\_ DSM-IV#: \_\_\_\_\_

Axis IV: \_\_\_\_\_ DSM-IV#: \_\_\_\_\_

Axis V: \_\_\_\_\_ DSM-IV#: \_\_\_\_\_

**2. INPATIENT HOSPITALIZATION HISTORY**

Facility / Address	From	To

Has the member ever exhibited harm to self or others? If so, explain.

\_\_\_\_\_

\_\_\_\_\_

Does the member have a history of D&A/MISA treatment? If so, explain.

Facility / Address	From	To

**3. CURRENT OUTPATIENT DAY PROGRAMMING (IOP, Partial, DBT, IT)**

Location: \_\_\_\_\_ Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Location: \_\_\_\_\_ Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

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**4. CURRENT MEDICATIONS**

Medication	Dosage	Frequency	Medication	Dosage	Frequency

**E. STRENGTHS, SUPPORTS, AND NEEDS**

For each area, please rate on a scale of 0 to 5 the level of assistance the individual needs or desires. Note the change the applicant wishes to make in that domain, if any. Also list their strengths in each of the domains.

0—Needs no assistance      1—Needs minimal assistance    2—Needs some assistance  
 3—Needs moderate assistance    4—Needs substantial assistance    5—Needs extensive assistance

Scale	Domain	Describe strengths, limitations, and goals in each domain
_____	Living:	_____
_____	Learning:	_____
_____	Working:	_____
_____	Socializing:	_____

**F. REFERRED BY:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Agency:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Email** \_\_\_\_\_

**MEMBERSHIP CHECKLIST**      All applicants will need to provide the following items:

- Psychiatric evaluation with a diagnosis (Axis I-V) signed by a psychiatrist
- Copy of medical insurance form
- Completed Membership Referral Form
- Signed Release of Information form

Applicant's Name: \_\_\_\_\_