Phoenix Adult Partial Hospitalization Program
Chestnut Ridge Counseling Services, Inc.

100 New Salem Road, Uniontown, PA 15401
Phone: 724-437-1151 Fax: 724-437-4915

Referral Form

Date of Referral: _____

Consumer Name: _____ **DOB:** _____

Address: _____

Phone: _____ **SSN:** _____

Insurance Type: _____

Insurance ID number: _____

Emergency Contact /Phone: _____

Referring Person/Agency: _____

Phone: _____

Reason for Referral: _____

_____

_____

_____

_____

Diagnostic Information:
Psychiatric Diagnoses: _____

_____

Current Medications: _____

_____

_____

Active Medical Problems: _____

_____

Current Treatment:

Agency:_____

Psychiatrist:_____ Therapist:_____

BCM/Agency:_____

Drug and Alcohol Issue:_____

Legal Issues:_____

Community Supports and Other Agency Involvement:_____

_____

Transportation:

Does this individual have transportation to the program? **Y** **N**

If yes, how will they get to the program?_____

If no, are they registered with FACT or what are their transportation needs?_____

_____

This individual is interested and agrees to a referral for adult partial hospitalization services.

Signature of client:_____ **Date:**_____

Signature of Referring Agent:_____