Greenwich, CT 06830

PATHWAYS, INC

Referral for Fellowship Program

175 Milbank Avenue Tel. 203-869-5656 Fax: 203-622-0993
Website www.pways.org

_ Please complete this application and email it to Applications@pways.org

SECTION I: GENERAL INFORMATION

Applicant's Name ____

Date of Birth____________________Sex________________S.S.No.________________________

Current Address____

____

____

Home Phone______________________________Cell Phone____________________________

Marital Status______________________________ Number of Children____________________

Current Living Situation (Check One)
__________Hospital___________Supervised Residence__________With Parents or Relatives
__________Independent Housing__________Other (Please Explain)_____________________
____

Emergency Contact's Name and Address ____

____

____

Telephone_________________________Relationship__________________________

Name of Conservator of Financial Matters (if any) Address______________________________

____Telephone____________________

Name of Conservator of Person (if any) Address____

____Telephone____________________

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SECTION II: REFERRAL SOURCE

Referred by: ______________________________ ______________________________
Name Title

Agency Name & Address ____

____

____

Telephone ____

Reason for Application ____

____

____

Is applicant aware of referral? ______________Yes ______________No

How does applicant feel about referral? ________________________________

____

SECTION III: PSYCHIATRIC DATA (This section must be completed by the primary treatment provider and signed by the prescribing physician.)

A. Current Psychiatric Diagnosis

Diagnosis: Axis 1 ________________________________

Axis 2 ________________________________

Axis 3 ________________________________

Axis 4 ______________Axis 5 ______________

Prognosis: ________________________________

Current mental status ________________________________

____

Precipitating cause of last hospitalization ________________________________

____

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Applicant's active symptoms and supports needed to maintain clinical stability
____
____
____

B. Hospitalization History

Hospitalizations since initial diagnosis__________

Age at first hospitalization ___________

Please list three most recent hospitalizations beginning with the most recent:

	Hospital	State	Dates	Precipitants
1.				
2.				
3.				

Elaborate on above, i.e. applicant's response to hospital environment, positive and negative, or approaches found useful in management:

____
____
____
____

C. Housing History Beginning with the Most Recent

	Name of Program/Agency	Dates
1.		
2.		
3.		
4.		

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D. Current Medications (Please attach additional sheet, if necessary)

Name	Dosage	Times Per Day
1. ____________	____________	____________
2. ____________	____________	____________
3. ____________	____________	____________
4. ____________	____________	____________

Is applicant capable of administering his/her own medication? __________________

What behaviors can be expected if applicant discontinues medication? _________________

____

____

Check any that apply:

___________ Alcohol/drug abuse within 30 days __________Sexually assaultive behavior

___________Past history of alcohol/drug abuse __________Suicidal behavior

___________Criminal charges pending _________History as victim of family violence

____________History of assaultive/criminal behavior ___________ Probation

____________History as perpetrator of family violence

Please explain any item checked____

____

____

Name, Address and Telephone of Prescribing Psychiatrist ____________________________

____

____

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Signature of Prescribing Psychiatrist ____

SECTION IV: COLLATERAL AGENCIES

Please list any other service providers who are currently working with the applicant

	Name	Agency	Telephone	Services Provided
1.	________________	___________________	___________	______________________
2.	________________	___________________	___________	______________________
3.	________________	___________________	___________	______________________
4.	________________	___________________	___________	______________________

Application completed by __________________________________ ________________
Name Date

Signature___________________________________

FG:df
Revised 08/2013