PATHWAYS

A Caring Path to Mental Health

Success Club at Pathways Application

Referral for: ____Fellowship Program ____Community Connections ____Master Mind

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 Estate/Finance (if any) _____

Address _____Telephone _____

Name of Conservator of Person (if any) _____

Address _____Telephone _____

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 _____

_____

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.	_____	_____

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3._____ _____

4._____ _____

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 _____

_____

Signature of Prescribing Psychiatrist _____

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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.				

SECTION V: INTERESTS

1. What types of activities is referral hoping/looking to engage in at the Success Club?

_____
_____
_____

2. What are some personal interests/hobbies of referral?

_____
_____
_____

3. Would referral like assistance in obtaining/maintaining employment or volunteer work? If so, what kind of work would they like to be doing? Do they have any previous work history?

_____
_____
_____

4. Does referral have an interest in going back to school? If so, what subjects is referral interested in?

_____
_____
_____

5. Does referral struggle with attention, memory, processing speed, or any other cognitive skills? If yes, please explain and indicate if they would be interested in working towards improving on these skills.

_____

_____

_____

6. Is referral "tech savvy" or do they struggle to use technological devices such as computer, smartphone, etc.?

_____

_____

_____

7. Is referral interested in increasing their socialization? Do they struggle to socialize? If so, what are some, if any, barriers to them socializing with others?

_____

_____

_____

Application completed by _____ _____

Name Date

Signature_____

Please email this application to our Clinical Director, Alessandra Pane, LCSW at apane@pways.org or fax to 203-900-3390.