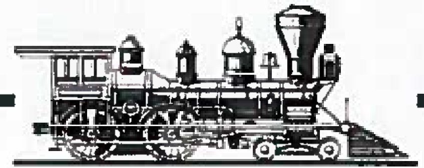
Union Station Clubhouse



100 Corporate Crossing Road, Uniontown, PA 15401
Phone: (724) 439-9311 Fax: (724) 439-9334
Web: www.unionstationclubhouse.com

Dear Referrer or Referring Agency:

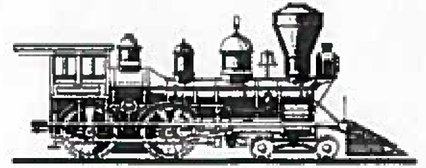
Due to the adoption of Pennsylvania Department of Public Welfare regulations. In addition to the previously required items, a NEW member will also need the following for admission to the Union Station Clubhouse:

- The attached recommendation form, signed from a Licensed Practitioner of the Healing Arts (LPHA) stating the member's diagnoses as well as what they recommend which goals the member would like to pursue while attending Union Station Clubhouse.
    - The form can only be signed by one of the following:
        - Medical Doctor, Psychiatrist (M.D., D.O.)
        - Physician's Assistant (PA, PA-C)
        - Certified Registered Nurse Practitioner (CRNP)
        - Psychologist (Psy. D., Psy. ABD)
- As always, a new admission to the Union Station Clubhouse program will also require copies of the following information:
    - Medical Insurance Cards
    - Social Security Card
    - Driver's License / Photo ID – Current and Valid.

If you have any questions, please do not hesitate to contact our staff at (724) 439-9311, we will try to assist you in any way that we possibly can.

Union Station Clubhouse Staff

Union Station Clubhouse Referral Form



Person Making Referral: ______________________
Agency: ______________________ Date of Referral: __________

Member Demographics

Individual Name: ______________________

Address: ______________________

City: ______________________ ZIP Code: __________

Contact Phone: ______________________ Age: __________

Date of Birth: __________ Medicaid ID #: __________

Social Security #: __________ Race/Ethnicity: __________

General Reason for Referral: ______________________
Check one: ____ Living ____ Learning ____ Working ____Socializing

Mental Health Information

Diagnosis Information

Axis	ICD9 Code	Clinical Name
I	*F* ______.____	______________________
II	*F* ______.____	______________________
III	*F* ______.____	______________________
IV	*F* ______.____	______________________
V	*F* ______.____	______________________

Treatment Information

Mental Health OP TX: ______________________ Phone: __________

Psychiatrist /Doctor: ______________________ Phone: __________

Therapist Name: ______________________ Phone: __________

BCM/ASM/SC: ______________________
Agency: ______________________ Phone: __________

Peer Specialist: ______________________
Agency: ______________________ Phone: __________

Psychiatric Evaluation

Completed By: ______________________ Date: __________

Medication Record

#	Medication Name	Dosage	Frequency	Used For
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Significant Medical Conditions / Disabilities *(specify)*:

___ Physical (Specify): ______________________________

___ Vision: ______________________________

___ Hearing: ______________________________

___ Developmental: ______________________________

___ Illicit Drugs: Explain: ______________________________

Alcohol Consumption: ___Social ___Moderate ___Excessive ____None

Medical Providers

Primary Care Physician: ______________________________
Office: ______________________________ Phone: ______________

Dentist: ______________________________
Office: ______________________________ Phone: ______________

Optometrist: ______________________________
Office: ______________________________ Phone: ______________

Pharmacy: ______________________ Phone: ______________

EDUCATION / VOCATIONAL TRAINING

School Name	City/State	Dates	Grade
____________________	______________	__________	_____
____________________	______________	__________	_____
____________________	______________	__________	_____

EMPLOYMENT HISTORY

Employer	Date Start / Finished	Reason for Leaving
____________________	____________________	________________
____________________	____________________	________________
____________________	____________________	________________

Did the member serve in the Military? ____ Yes ___ No
If Yes: Branch: __________________ Dates: ______________________

LEGAL ISSUES

Have you ever been arrested or placed on probation? *YES* *NO*
(Circle One Choice)

If YES, Explain:

____

____

____

Charges Pending YES NO N/A
(Circle One Choice)

FINANCIAL INFORMATION

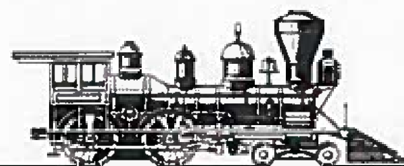
___*Social Security:* ___ *SSDI* ____ *SSI* ____ *Retirement*

___ *Department of Public Welfare (General Assistance)*
___ *Veterans' Benefits* ____ *Pension* _____*Salary* _____ *other*

Does the member have a support contact? ___ Yes _____ No

If Yes, Who is it? Name: ______________________________________
Agency: ______________________________________
Phone: ______________________________________

Union Station Clubhouse



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To whom it may concern:

Please complete the attached form so the individual requesting to participate in the Union Station Clubhouse program of Goodwill of Southwestern Pennsylvania will be permitted to begin the program.

As per Pennsylvania Department of Public Welfare regulations, we are required to receive a recommendation from a Licensed Practitioner of the Healing Arts (LPHA).

An Licensed Practitioner of the Healing Arts (LPHA)must be ONLY be one of the follwling:

- The form can only be signed by one of the following:
    - Medical Doctor, Psychiatrist (M.D., D.O.)
    - Physician's Assistant (PA, PA-C)
    - Certified Registered Nurse Practitioner (CRNP)
    - Psychologist (Psy. D., Psy. ABD)

After completion, please FAX the form to the attention of Scott Bombach, Program Director of Union Station Clubhouse at (724) 439-9334 or mail to:

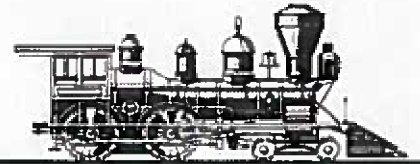
Union Station Clubhouse
100 Corporate Crossing Road
Uniontown, Pennsylvania 15401-3347

Thank you in advance for your cooperation.

Sincerely,

Scott Bombach, B.S., CPRP
Program Director
Union Station Clubhouse
Affiliate of Goodwill of Southwestern Pennsylvania

Union Station Clubhouse



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As a Licensed Practitioner of the Healing Arts (LPHA). I recommend the following individual, ________________________________ to be a member of Union Station Clubhouse (an affiliate of Goodwill of Southwestern Pennsylvania) to work on one of the following environments:

_____ *Living* ____*Learning* _____ *Working* ____ *Socializing*

The individual has the following Mental Health Diagnosis listed on one of the two AXIS:

AXIS I: F.________.____/ F ______.____

AXIS II: F.________.____/ F ______.____

Please write a short comment as to how the individual will benefit from participating in the Union Station Clubhouse Program:

____

____

____

Printed Name & Credentials of LPHA: ________________________________

*Signature and credentials of LPHA:*________________________________

Date of Signature: ________________________

EMERGENCY MEDICAL INFORMATION

MEMBER NAME: ___ ______________________________

EMERGENCY CONTACT:

NAME:______________________ PHONE DAY:____________ _____ _____

RELATIONSHIP:______________________ EVENING:____________________

CASE MANAGER NAME: ________________________ PHONE:____________________

THERAPIST:________________________________ PHONE:____________________

RESIDENTIAL STAFF:____________________________ PHONE:____________________

PSYCHIATRIST:_______________________________ PHONE:____________________

PRIMARY MEDICAL DOCTOR______________________ PHONE:____________________

OTHER (if any) DOCTOR ________________________ PHONE:____________________

MEDICAL INSURANCE PROVIDER __________________ INSURANCE #__________________

MEDICATIONS (use back if necessary:

NAME OF MEDICATION	DOSAGE	FREQUENCY	What medication is for
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

MEDICAL CONDITIONS (circle all that apply):

High Blood Pressure **Diabetes** Asthma Seizures Deaf/Hearing Impaired Other: _______________

ALLERGIES:

Food: ______NA_________________________________

Drug: ______NA_________________________________

Other: _____NA_________________________________

I verify that the above information is accurate and complete. If I am prescribed a new medication or my medication dosage or frequency changes I will notify the Union Station Clubhouse within 30 days.

____________________________________ ________________________

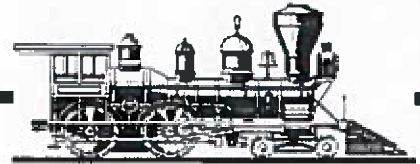
Member Signature Date

____________________________________ ________________________

Staff Signature Date

revised: 12/20/1

Union Station Clubhouse



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CONSENT FOR SERVICES

I consent to participate in Psychiatric Rehabilitation Services through Union Station Clubhouse and Goodwill of Southwestern Pennsylvania.

Member Signature: ______________________________ Date: __________

(Request for Psychiatric Evaluation)

Union Station Clubhouse
100 Corporate Crossing Road
Uniontown, PA 15401

Permission for Use/Disclosure of Health Information

Member Name: ________________________

SS#: ____________________________ **Date of Birth:** _________________

I give my consent to _________________________ **to disclose information from my record to** ________ **Union Station Clubhouse** _________ **for the purpose of:**

X Determining eligibility for Union Station Clubhouse
__ Other: __________________________________

I understand that the information released will be limited to the following marked items:

___ Diagnosis
___ Attendance
__ Prognosis
__ Educational Goals
__ Vocational Goals
__ General Physical
X Psychiatric Evaluation
__ Medications/Rx
___ Other (please specify): ___________________________

I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that Union Station Clubhouse has already relied upon it, of if this Authorization was signed as a condition of obtaining insurance coverage. In order to revoke this Authorization I understand that I must do so in writing. I also understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information, and may no longer be subject to the privacy protections provided to me by law.

Date: ______________ Signature: ______________________________________

This Authorization expires on: ___________________

Date: _______________ Witness: _____________________________________

If you are the legal representative of the person listed above, please note the basis for your authority:
☐ Power of Attorney (attach copy) ☐ Guardianship Order (attach copy)
☐ Custody Order (attach copy)