

**LEHIGH COUNTY RESIDENTIAL/MPRS REFERRAL FORM**

Please check as appropriate:

- Step-By-Step Full Care C.R.R.** (24hr Residential)
- Transitional Living Center Full Care CRR** (24hr Residential)
- Transitional Living Center Moderate Care CRR** (10hr Residential)
  
- Step-By-Step Mobile Psych Rehab Service**  
(This referral for Psych Rehab is Non-Residential/Non-Magellan eligible only)

**In an effort to be environmentally friendly, referrals to the long term residential programs listed below will be screened and then forwarded to the appropriate agency by Lehigh County.**

- AIR RHD** - All-Inclusive Residential – Hope Springs
- AIR Horizon House**– All Inclusive Residential–Trestle House
- NHS** – Enhanced Personal Care Home
- SBH** – Enhanced Personal Care Home – Acorn
- Horizon House SAL**–Supervised Apartment Living–The SHORE
- SBH** – Supported Housing

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Name: \_\_\_\_\_

County Case# \_\_\_\_\_

Current Address: \_\_\_\_\_

ICM/ACT/Casemanager: \_\_\_\_\_

Current Living Arrangement: \_\_\_\_\_

Current Psychiatrist: \_\_\_\_\_

Current Phone: \_\_\_\_\_

Location: \_\_\_\_\_ Ph#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Diagnosis:

Marital Status: \_\_\_\_\_ Gender: \_\_\_\_\_

Axis I: \_\_\_\_\_

Education (highest grade completed): \_\_\_\_\_

DSM-IV Code# \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Axis II: \_\_\_\_\_

DSM-IV Code# \_\_\_\_\_

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

Axis III: \_\_\_\_\_

DSM-IV Code# \_\_\_\_\_

Relationship: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

Monthly Income: \_\_\_\_\_ Source(s): \_\_\_\_\_

Current day programming: \_\_\_\_\_

MA/Magellan:    yes                                    no

Outstanding medical conditions / physical limitations: \_\_\_\_\_

Medicare:        yes – A   B   D                    no

Other insurance: \_\_\_\_\_

Representative Payee: \_\_\_\_\_

Family Physician: \_\_\_\_\_

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

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

Legal Charges (Past AND Present): \_\_\_\_\_

Probation / Parole Officer Name: \_\_\_\_\_

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

**Drug and Alcohol History:** \_\_\_\_\_

**Suicidal Behavior / Attempts:** \_\_\_\_\_

**History of Violence:** \_\_\_\_\_

**Decompensation Pattern:** \_\_\_\_\_

**Fire Setting History:** \_\_\_\_\_

**Past Agency / Hospital / Treatment Involvement:**

Hospital / Agency / Treatment Facility Name & Address

Dates


**REASON FOR REFERRAL ..... PLEASE BE AS SPECIFIC TO THE INDIVIDUAL'S NEEDS AS POSSIBLE:**


**In order to expedite the referral process, please include the following (check if included):**

- Most recent Psychiatric Evaluation
- Most recent Medical Examination
- Psychosocial History
- Results of Criminal Record Check
- Signed Releases of Information for any previous treatment involvement / hospitalization

**ALL REFERRALS NEED TO BE FORWARDED TO LEHIGH COUNTY FOR REVIEW:**

- Lehigh County MH/MR**  
17 S. 7<sup>th</sup> St.  
Allentown, PA 18101  
Att: CRR / SLS Liason  
**FAX #: 610-820-3689**  
**OR 610-871-1455**

**CRR/MPRS REFERRALS NEED TO BE FORWARDED TO THE APPROPRIATE AGENCY (please check as completed):**

- Step By Step**  
623 W. Union Blvd.  
Bethlehem, PA 18018  
Att: Christine Stendell  
**FAX#: 610-882-2497**
- T.L.C.**  
264A S Levan St  
Allentown, PA 18102  
Att: Nancy Beidler  
**FAX#: 610-841-5324**