



**RTP REFERRAL SCREENING**

Consumer Name:

DOB:

Age:

Social Security:

Income:

Insurance:

BSC/ASC/CTT/ECCM Name/Agency/Number:

<b>Current Housing/Previous Address</b>	
<b>Support/Family Involvement</b>	
<b>Detailed discharge plan from DAS</b>	
<b>Diagnosis</b>	
<b>Current Functional Status</b>	
<b>Presenting/Current Symptoms</b>	
<b>Suicide History (Ideation/Attempts) Last attempt?</b>	
<b>Current Suicide Thoughts</b>	

<b>Homicidal Ideation (Past and Current)</b>	
<b>Hallucinations (Command or other)</b>	
<b>Assaultive/Aggressive</b>	
<b>Current Medication (Clozaril or injectables) Compliant?</b>	
<b>Medical Issues (Ambulatory? Contagious Diseases?)</b>	
<b>Psychiatric History (Outpatient, hospitalizations, etc.) Outpatient ECT?</b>	
<b>Legal Issues (past or present, parole/probation, assault, fire setting)</b>	
<b>D&amp;A History/Current Use</b>	
<b>Other Information (education, marital status, race/ethnicity)</b>	
<b>Physical Exam/Lab work</b>	
<b>Date of discussion of PRNs with Social Worker</b>	

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Staff Signature

Date

\*Please fax completed referrals to the medical records dept. (412) 257-2008\*

For more information email: [rtpreferrals@chartierscenter.org](mailto:rtpreferrals@chartierscenter.org)