629 North Market St.
Lancaster, PA 17603
Phone: (717) 392-8536 Fax: (717) 392-7697

This form is designed to obtain pertinent information about potential members of Arch Street Center. To avoid delay, please provide all requested information. All fields are required but may be marked N/A if inapplicable to the applicant. The form must be completed and returned *by the referral source*, not by the applicant themselves.

- Return this form to the Arch Street Center Member Ambassador at brad@archstreetcenter.org or fax to (717) 392-7697
- Include a HIPAA Release of Information form signed by the applicant
- Inform the applicant to contact the Center at (717) 392-8536 to schedule an intake.

Per HIPAA regulations, referrals are valid for a period of 90 days

Date of Referral: _____Name of Applicant: _____

Applicant Address: _____ Phone: _____

_____ Email: _____

Date of Birth: _____ BH/DS/EI BSU#: _____ Veteran: ☐ Yes ☐ No

Living Arrangement: ☐ Independent ☐ Family ☐ Group ☐ TTC ☐ Unhomed ☐ Other

Diagnosis:
Please be as specific as possible. If the applicant is dual diagnosis with intellectual disability the MH diagnosis must be primary and membership acceptance will be at the discretion of the Center director.

☐ Depression ☐ Anxiety ☐ Schizophrenia ☐ Schizoaffective ☐ PTSD* ☐ Other

Please specify: _____

**PTSD is a provisional diagnosis. Membership acceptance will be at the discretion of the Center director.*

Signs of Regression: _____

_____

Psychiatric Hospitalizations (most recent dates/where): _____

_____

Present Medications/Pertinent Medical Information: _____

_____

Allergies: ☐ Yes ☐ No If yes, please list: _____

629 North Market St.
Lancaster, PA 17603
Phone: (717) 392-8536 Fax: (717) 392-7697

Legal Involvement: ☐ Yes ☐ No If Yes, specify charges/dates: _____

_____

Name of Probation Officer: _____ Mental Health Court Participant: ☐ Yes ☐ No

History of Substance Abuse: ☐ Yes ☐ No If Yes, please specify most recent use, status of recovery and participation in recovery programs. The Center may require a minimum period of recovery or other conditions per our drug and alcohol policy requirements:

_____

_____

History of Violence: ☐ Yes ☐ No If Yes: ☐ Toward Self ☐ Toward Others ☐ Toward Property

Please Specify: _____

_____

Strengths & Interests: _____

_____

Additional Information: _____

_____

Emergency Contact:

Name: _____

Address: _____

Phone: _____

Email: _____

Relationship: _____

Referral Source:

Name: _____

Address: _____

Phone: _____

Email: _____

Agency: _____

Case Manager *(if different from Emergency Contact):*

_____