

APPLICATION FOR SERVICE

PATHWAYS, INC.

175 Milbank Avenue • Greenwich, CT 06830 • Tel. 203-869-5656 • Fax 203-869-4059

Please complete all sections of this application thoroughly. Section III must be completed by the primary treatment provider and signed by the prescribing physician.

SECTION I: GENERAL INFORMATION

Applicant's Name _____

Date of Birth _____ Sex _____ S.S. No. _____

Current Address _____

Telephone _____

Marital Status _____ No. 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 Financial Matters (if any) _____

Address _____

Telephone _____

Name of Conservator of Person (if any) _____

Address _____

Telephone _____

SECTION II: SOURCE AND PURPOSE OF REFERRAL

Please check all services which are being requested at this time:

_____ Milbank Community Residence _____ Fellowship Club
_____ Davis Supervised Apartment Program _____ Outreach & Support Services (RSS Program)

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

Total No. of hospitalizations since initial diagnosis _____

Age at first hospitalization _____

Please list all hospitalizations beginning with the most recent:

<u>Hospital</u>	<u>State</u>	<u>Dates</u>	<u>Precipitants</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

Elaborate on above, i.e. applicant's response to hospital environment, positive and negative, or approaches found useful in management:

C. Residential Program History Beginning With the Most Recent:

<u>Name of Program/Agency</u>	<u>Dates</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

D. Current Medications (Please attach additional sheet, if necessary):

<u>Name</u>	<u>Dosage</u>	<u>Times Per Day</u>
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 or perpetrator of family violence (circle one)
- _____ History of assaultive/criminal behavioral _____ Probation

Please explain any item checked: _____

Name, Address, and Telephone of Prescribing Physician _____

Signature of Prescribing Physician _____

SECTION IV: COLLATERAL AGENCIES

Please list any other service providers who are currently working with the applicant:

	<u>Name</u>	<u>Agency</u>	<u>Telephone</u>	<u>Services Provided</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Application Completed by: _____

Name Date

Signature

Attachments: Statement of Ability to Self Medicate (Residential Applicants only)
Physical Examination Report (Residential Applicants Only)