PROGRAMS FOR PEOPLE, INC.

98 Lincoln Street   Framingham, MA 01702   TEL (508) 879-3230   FAX (508) 872-8724

Laura Hughes, PMHCNS-BC, Administrative Director
Ethan Harris, LICSW, Clinical Director

Date received: ___/___/___
Date screened: ___/___/___

PROJECT ADVANCE REFERRAL FORM

PROJECT ADVANCE TEL (508) 620-1730   Tony Sirignano, MPA, Employment Services Manager

Please fill out the entire form - do not leave any questions blank
If the individual you are referring already has an MRC Counselor please contact us before completing this form.

Referrant: ____ Date:____________________
Organization: ______________________________ Telephone : ______________ Fax:______________
Clinician's Signature: ______________________________ License #: ______________________________

The Project Advance Referral form MUST be completed and signed by a Licensed Clinician.
Applicants with a Diagnosed Substance Abuse History must be **SOBER** for a minimum of **3 MONTHS** prior to their referral to the program.

WHAT IS THE APPLICANT'S RESPONSE TO THIS REFERRAL? ______________________________

IDENTIFYING INFORMATION

Applicant's Name: ____ Date of Birth:______________
Home Address: ____ Telephone : ________________
Social Security Number: ______-______-______

INCOME:

Source	Amount	Source	Amount	Source	Amount
SSI	____________	Private Disability	______________	Unemployment	__________
SSDI	___________	Other	______________________	*Family Income	_________

*Family income may determine eligibility for Mass. Rehabilitation Commission Services

PRESENTING PROBLEMS

DSM III Diagnosis and NO.: (AXIS I): ____
(AXIS II): ____

Briefly describe the duration, frequency and severity of symptoms. Include your understanding of major precipitants:

Describe any suicidal / homicidal gestures or attempts:

Explain if any of the following apply to the applicant:
Cognitive Issues: ____
Assaultive Behavior: ____
Involved in court action/and CORI: ____

SIGNIFICANT FAMILY ISSUES:

____
____

CURRENT MEDICATIONS (Name of drug, dosage/frequency)

______________________________   ______________________________
______________________________   ______________________________

SIGNIFICANT MEDICAL HISTORY AND ALLERGIES: ______________________________
____

SUBSTANCE ABUSE HISTORY

Name of Substance	Amount of Use	Frequency	Treatment	Date of Last Use

Does applicant consider substance use a problem? Yes: ____________ No: ____________
What is applicant's commitment to sobriety? ____
What is the plan to attain/maintain sobriety? ____

OCCUPATIONAL CHOICES

List type of job(s) which applicant would like to pursue based on his/her ***current skills*** & interests:

1. ____
2. ____
3. ____

EMPLOYMENT IMPRESSIONS – All categories listed below MUST be completed.
Please list applicant's strengths and weaknesses in **all** of these areas.

[ ] Communication: ____
[ ] Self-Direction: ____
[ ] Interpersonal Skills: ____
[ ] Mobility / Medical Concerns: ____
[ ] Self-Care: ____
[ ] Work Skills: ____
[ ] Work Tolerance: ____

PSYCHIATRIC TREATMENT HISTORY

Name of Hospital	Precipitant(s)	Admission Date	Discharge Date

OUTPATIENT TREATMENT TEAM

	Name	**Telephone #**
Current Therapist		
Medicating Psychiatrist		

EDUCATION LEVEL/DEGREE: ____________________ **APPLICANT'S OCCUPATION**: ____________________

EMPLOYMENT HISTORY (Please list most recent job first):

Name of Company	Title	Dates of Employment	List Barriers on Job	Reason for Leaving

PLEASE FEEL FREE TO SUBMIT ANY INFORMATION THAT YOU BELIEVE WOULD BE HELPFUL IN DETERMINING ACCEPTANCE INTO PROJECT ADVANCE.