

Referral to Charles Webster Potter Place

1. Please have the C.W. Potter Place referral form filled out by a prospective member's Doctor, Psychiatrist, Therapist, Case Manager, Mass Rehab worker, etc. We encourage the prospective member to be involved in the writing of the referral and to have input into what information is included in it.

2. Upon completion, the referral gets mailed to:

Charles Webster Potter Place
15 Vernon Street
Waltham, MA 02453
Attention: Program Director

Fax to: 781 891.3812

3. When we receive the referral we will call the prospective member to set up a-Guest Day. Guest Days are held on Tuesdays and Thursdays from 9 a.m. -2 p.m. This gives the prospective member an opportunity to be involved in the prevocational work ordered day by spending time in each of the three work areas, along with gaining more information on our vocational and educational supports. The member would also use this as an opportunity to ask questions and fill out some necessary paperwork.

4. The prospective member or referring person must call the Department of Mental Health's Arlington Case Management Office at 781 641.1980 and tell them you are looking to become eligible for C W: Potter Place services. They will send a separate form for you to fill out.

5. If you already have a DMH Case Manager, you are eligible.

6. When you receive notification about whether or not a member is eligible, please inform the Intake Coordinator at C.W. Potter Place. If you are deemed ineligible, this will not interfere with the member's status.

7. If you have any questions or concerns regarding this process, we encourage you to call the Intake Coordinator at 781 894.5302.



15 Vernon Street, Waltham, MA 02453
Tel: 781.894.5302 Fax: 781.8913812 E-mail: potterplace@msn.com

*Referral Form
C. W. Potter Place Clubhouse Services
A Program of the Center for Mental Health and Retardation Services, Inc.*

Date: _____
Member Name _____
Date of Birth: _____
Current Address _____ Permanent Address: _____

Phone Number: _____
Referred By: _____
Referring Agency: _____ Phone: _____

PLEASE DESCRIBE REASONS FOR COMING TO POTTER PLACE:

- To be involved in the structure of a work ordered day
- To improve existing work skills, learn new skills
- To get back to work
- To work on education
- Other: explain: _____

Please forward the completed referral to:

C.W. Potter Place	Phone: 781 894.5302
Attention: Program Director	Fax: 781 891.3812
15 Vernon Street	E-mail: potterplace@msn.com
Waltham, MA 02453	

For Administration Office Use Only

Date Received: _____ Date Entered: _____

Marital Status: _____

Gender: _____

Social Security #: _____

PROVIDERS:

Therapist: _____

Phone: _____

DMH Case Manager: _____

Phone: _____

House Manager: _____

Phone: _____

Psychiatrist: _____

Phone: _____

Mass. Rehab.: _____

Phone: _____

Legal Guardian: _____

Phone: _____

Address: _____

Rep. Payee: _____

Phone: _____

Address: _____

Other: _____

Phone: _____

DSMIV DIAGNOSIS:

Axis I _____

Axis III _____

Axis II _____

Axis IV _____

Axis V _____

Signs/Symptoms of Decompensation: _____

MEDICATION:

Type

Dosage

Frequency

HISTORY:

Family: (significant family members and relevant areas, i.e. mental illness, alcohol/drug abuse, sexual and/or physical abuse)

Psychiatric: (please give a description of when this person began experiencing difficulties and treatment that has occurred)

History of Suicidal and/or Assaultive Behavior:

Does the person have any legal action pending? If so, please explain. (i.e. probation officer, etc.):

History of Alcohol or Drug Abuse:

Allergies and/or Medical Conditions:

Previous Hospitalizations: (please begin with most recent)

	Hospital	Dates	Precipitant
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Previous Day Program Placements: (List most recent first)

Type/Name	Dates/Duration	Reason for Leaving
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Previous Residential Program Placements: (List most recent first)

Type/Name	Dates/Duration	Reason for Leaving
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

HEALTH INSURANCE INFORMATION:

Medicaid # _____ Medicare # _____
Other Insurance: _____
Company Name: _____ ID# _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name: _____ Relationship: _____
Address: _____
Phone: _____

FINANCIAL/INCOME:

Source or Income: (please check all that apply):

SSI SSDI Family Pension Wages Other

If wages or other, please explain: _____

HOUSING: (please describe current housing situation) _____

EDUCATION and EMPLOYMENT HISTORY

Last Grade Completed:

Degree/Cert. Year:

Name and location of school:

Special Training: _____

Where: _____ Year: _____

Educational Goals: _____

Employer Type of Work Dates of Employment Reason for Leaving

(List most recent job first; include volunteer work) _____

Special Training: _____

Where: _____ Year: _____

Employment Goals: _____

Other Relevant Information: _____

Consumer Signature: _____

Date: _____

Signature: _____

Date: _____

Title: _____

The Center for Mental Health and Retardation Services, Inc.

RELEASE TO SEND INFORMATION

The standard release of information must be completed and signed by consumer/guardian prior to any request of either verbal or written information.

I, _____, authorize

Name of Consumer

Name of Organization/Provider

to release records to: **Charles Webster Potter Place**
The Center for Mental Health and Retardation Services, Inc.

15 Vernon Street Waltham, MA 02453
The Center for Mental Health and Retardation Services, Inc. Clubhouse Address

Consumer Name: _____

Consumer Signature: _____

Witness: _____

Date: _____