711 6th Ave. N., Ste. 101
Seattle, WA 98144
206.501.3730
206.501.3733 (fax)
seattleclubhouse.org

Seattle CLUBHOUSE
A program of HERO House NW

To: _____
MENTAL HEALTH PROVIDER, AGENCY

From: _____
MEMBER / CLIENT

_____
DATE OF BIRTH | SSN OR GOVT. ID | PHONE#

_____
ADDRESS | CITY | STATE | ZIP

Re: Membership at HERO House

I have identified a desire to join Seattle Clubhouse. I hereby request that a referral be made to Seattle Clubhouse for my membership and participation in the clubhouse as part of my recovery plan. Please include Clubhouse Services in my Individual Service Plan (ISP) as an intervention that will be of benefit to me.

_____
MEMBER/ CLIENT SIGNATURE | DATE

Membership Referral

This following information is to be completed by Psychiatrist / Mental Health Care Provider:

_____
DATE OF LAST HOSPITALIZATION* | NAME OF FACILITY

Precipitating Factors: _____

Mental Health Diagnosis: _____
Use ICD-10 F codes (e.g. F43.1 PTSD)

Current Medications: _____

Reason for Referral / Goals: _____

Does prospective member have a history of violent behavior?	☐ Yes	☐ No
Has there been any legal involvement?	☐ Yes	☐ No
Does prospective member have a history / risk of suicide attempts?	☐ Yes	☐ No
Does prospective member have a history of alcohol / drug abuse?	☐ Yes	☐ No
Does prospective member have access to independent transportation?	☐ Yes	☐ No

If you answered "yes" to any of the above, indicate dates, behaviors, precipitants, legal actions and other pertinent details.

_____

_____

Additional Comments: _____

This request has been received and Clubhouse Services will be incorporated in the Client (Member) ISP

_____
NAME OF MENTAL HEALTH CARE PROVIDER: | **NAME OF REFERING AGENCY**

_____
SIGNATURE OF MENTAL HEALTH CARE PROVIDER:

711 6th Ave. N., Ste. 101
Seattle, WA 98144
206.501.3730
206.501.3733 (fax)
seattleclubhouse.org

Seattle CLUBHOUSE
A program of HERO House NW

Information Release

NAME: FIRST M.I. LAST DATE

DATE OF BIRTH SSN OR GOVT. ID

ADDRESS: STREET APT.

CITY STATE ZIP

I authorize Seattle Clubhouse (1265 S. Main Street, Suite 101, Seattle, WA, 98144) to release and/or receive information regarding my:

(please initial all)

_____ **Seattle Clubhouse Referral Form**

_____ **Treatment Plan Identifying Clubhouse Service**

_____ **Psychiatric Evaluation**

_____ **Treatment Summary**

_____ **progress Notes**

_____ **Physical Examination**

_____ **Alcohol/Drug Use Evaluation**

_____ **Educational History Status**

_____ **Psychological Evaluation/Testing Report**

_____ **HIV/AIDS Testing/Status Report**

_____ **Initial Assessment**

_____ **Other (Please specify)**

To (Mental Health Provider):

NAME BUSINESS

ADDRESS: STREET

CITY STATE ZIP

PHONE FAX

I understand that this release of information is for the purpose of my membership at Seattle Clubhouse. This information includes information collected from me or created by a Provider, or information received by the Provider from another health care provider, a health plan, my employer, a health care clearinghouse, or other community sources. Health information may relate to my past, present, or future physical or mental health or condition, the provision of my health care, or payment for my health care services. Furthermore, I understand that my personal health records are protected under State WAC 388-865 and RCW 71.05 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This consent releases my protected health information to be transmitted by telephone, fax or mail.

I understand that I may revoke this consent, in writing, at any time except to the extent that Seattle Clubhouse has already released and/or received information in reliance on this form.

MEMBER SIGNATURE **DATE**

WITNESS SIGNATURE **DATE**