711 6th AVE N Unit 101
Seattle, WA 98108
206.501.3730
206.501.3733 fax
www.seattleclubhouse.org

To: _____
MENTAL HEALTH PROVIDER, AGENCY

From: _____
MEMBER / CLIENT

_____
DATE OF BIRTH SSN OR GOVT. ID PHONE#

_____
ADDRESS

Re: Membership at Seattle Clubhouse

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: _____ _____

Current Medications: _____

Reason for Referral / Goals: _____

Does member have a history of violent behavior?	☐ Yes	☐ No
Has there been any legal involvement?	☐ Yes	☐ No
Does member have a history / risk of suicide attempts?	☐ Yes	☐ No
Does member have a history of alcohol / drug abuse?	☐ Yes	☐ No
Does 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: _____

_____

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Medical Insurance

☐ Straight Medicaid Provider:_____ ID #_____ Effective Date:_____

☐ Medicare Provider:_____ ID #_____ Effective Date:_____

☐ Private Provider:_____ ID #_____ Effective Date:_____

If Medicaid Managed Care, please include name of managed care company: _____

Medical Conditions and Alerts

☐ Mobility Impairment ☐ Severe Allergic Reactions ☐ New Psychiatric Medication

☐ Asthma ☐ Blind/Visual Impairment ☐ Deaf/Hearing Impairment ☐ Hypertension

☐ Epilepsy/Seizure Disorder ☐ Emphysema ☐ Diabetes

☐ Other:

_____

_____

_____

Provider Contacts

_____ _____ _____

PRIMARY CARE PHYSICIAN AGENCY PHONE

_____ _____

ADDRESS STREET APT.

_____ _____ _____

CITY STATE ZIP

_____ _____

INSURANCE PROVIDER POLICY NUMBER

_____ _____ _____

MENTAL HEALTH PROVIDER AGENCY PHONE

_____ _____

ADDRESS STREET APT.

_____ _____ _____

CITY STATE ZIP

_____ _____

INSURANCE PROVIDER POLICY NUMBER

Psychiatric Hospitalizations

Has the member ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, have they been hospitalized in the last 6 months? ☐ Yes ☐ No

Total Number of psychiatric hospitalization on record _____

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: DATE:

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