HOPE CLUBHOUSE
Changing lives through Hope

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REFERRAL FORM

Membership Requirements:
1. Referral Form signed by Clinician
2. *Psychiatric Evaluation (if applicable)

PROSPECTIVE MEMBER INFORMATION

(NAME) _____ (DATE OF BIRTH) _____

(ADDRESS) _____ (SOCIAL SECURITY NUMBER) _____

(CITY) _____ (STATE) _____ (ZIP) _____ (PHONE NUMBER) _____

INFORMATION BELOW TO BE FILLED OUT AND SIGNED BY MENTAL HEALTH PROVIDER

DIAGNOSIS		MEDICATION	
Axis I		1	
Axis II		2	
Axis III		3	
Axis IV		4	
Axis V		5	

Medicaid Recipient? □ Yes □ No □ HMO _____
Reason for Referral/Goal: _____

RISK ASSESSMENT

BEHAVIOR	HISTORY	CURRENT ACTIVITY LEVEL
Violence	□ Yes □ No	□ None □ Minimal □ Moderate □ High
Suicide attempt(s)	□ Yes □ No	□ None □ Minimal □ Moderate □ High
Alcohol/drug abuse	□ Yes □ No	□ None □ Minimal □ Moderate □ High
Sexual Exploitation	□ Yes □ No	□ None □ Minimal □ Moderate □ High

Describe any legal involvement: _____
Comments on any of above: _____

(MENTAL HEALTH PROVIDER NAME AND CREDENTIALS) _____ (PHONE) _____

(AGENCY NAME) _____ (DATE) _____

(AGENCY ADDRESS) _____

(CITY) _____ (STATE) _____ (ZIP CODE) _____

MENTAL HEALTH PROVIDER SIGNATURE