**Clubhouse of Lehigh County**

**MEMBERSHIP REFERRAL FORM**

**IMPORTANT**: Please select the appropriate **REFERRAL TYPE**:

**CIRCLE ONE**

 STANDARD CLUBHOUSE MEMBERSHIP

 MEMBERSHIP/YOUNG ADULT TRANSITION PROGRAMMING

“Unknown” may not be used. None = None

N/A = Not Applicable

Referring Office/Agency: Person Completing the Referral: Phone: Name of Applicant: Date of Birth: Address: Apt. # City: State: Zip Code: County: Home Phone: Cell Phone:

Social Security Number: - - Email:

Gender: Male

 Female

Race: 1=Black or African American 3=American Indian/Alaskan Native

 4=Asian

 5=White

 7=Native Hawaiian or Other Pacific Islander

 6=Other/Not Volunteered by Recipient

**Health Insurance Information**

MA Access #

Medicare

Medical Assistance HMO

Medicare HMO

Private Health Insurance Plan

**For Office Use Only**

 Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vocational Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Living Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Population Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENTAL HEALTH TEAM**

|  |  |  |  |
| --- | --- | --- | --- |
| **PROVIDER GROUP** | **MAIN STAFF/CLINICIAN** | **PHONE NUMBER** | **CELL PHONE NUMBER** |
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**PRIMARY CARE PROVIDERS**

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| --- | --- | --- | --- |
| **PROVIDER GROUP** | **MAIN CLINICIAN** | **ADDRESS** | **PHONE NUMBER** |
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**PLEASE INDICATE ALL THAT APPLY:**

 Intellectual Disability — **If yes, indicate IQ** Comment:

Learning Disability — Comment:

Attention Deficit Disorder (ADD) — Comment: Perceptual Impairment — Comment:

Auditory Impairment — Comment: Autism — Comment:

Asperger’s Disorder — Comment: Visual Impairment — Comment: Physical Disabilities — Comment: Seizure Disorder — Comment: Other — Please Specify:

Medical Conditions — Please Specify:

Allergies —Please Specify:

**REASONS FOR REFERRAL / DESIRED OUTCOMES**

**For each area of FUNCTION, rate the applicant’s current LEVEL using the Key below.**

**Then describe the DESIRED CHANGE the applicant wants to make in each area.**

**KEY**

**0 = No Assistance Needed 1 = Needs Mild Assistance**

**2 = Needs Moderate Assistance 3 = Needs Extensive Assistance**

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| --- | --- | --- |
| **FUNCTION** | **LEVEL (Number from Key)** | **DESIRED CHANGE****(A Description in Words)** |
| **EDUCATION** |  |  |
| **SOCIAL** |  |  |
| **VOCATIONAL** |  |  |
| **SELF MAINTENANCE DAILY LIVING SKILLS** |  |  |
| **SELF MAINTENANCE****MANAGING ILLNESS & WELLNESS** |  |  |

**EDUCATION HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TYPE OF EDUCATION** | **NAME OF SCHOOL** | **HIGHEST****GRADE** | **DATES** | **DIPLOMA/MAJOR** |
| **HIGH SCHOOL/GED** |  |  |  |  |
| **TRADE OR TECH** |  |  |  |  |
| **COLLEGE** |  |  |  |  |
| **OTHER** |  |  |  |  |

**Is the applicant involved in any educational/training programs at the present time: \_Yes \_No**

**If yes, please describe the program:**

**Does the applicant have an interest in further education: Yes**

 **No**

**If yes, please describe what kind of education:**

**THIS PORTION OF THE REFERRAL FORM MUST BE COMPLETED BY A PSYCHIATRIST OR THERAPIST**

**Name of Clubhouse Applicant**

**Name of Psychiatrist/Therapist Address**

**Phone**

**BEHAVIORAL HEALTCH CARE INFORMATION PSYCHIATRIC MEDICATIONS**

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**Psychiatric Diagnosis (DSM # must be included.)**

Axis I DSM #

Axis II

DSM #

Axis III Axis IV

Axis V

**Current D & A Use**

Type? Frequency?

**Current D & A Treatment**

Attend 12-Step Meetings?

Frequency?

Yes No

Describe any presence of significant harm to self, others or property, or any unusual behaviors.

Give dates and details:

Describe any incidents of violence, arrests, prison terms, fire setting.

Give dates and details:

Describe any current legal involvement (DUI, custody, probation, parole, etc.

Give dates and details:

Parole/Probation Officer: Name

Phone

**Signature of Psychiatrist/Therapist Date**

Is the applicant currently working? Yes No If yes, what is the job title? If yes, give company name

If yes, give the days and hours worked each week

Describe any previous work experience the applicant has.

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Does the applicant have any volunteer experience? Yes No

If yes, where did the applicant volunteer? If yes, what kind of volunteer work was it?

List the applicant’s hobbies, talents or special interests.

What would the applicant like to accomplish by coming to Clubhouse?

***Notice to Clubhouse Applicant***: *All member information is confidential. Staff/members are responsible for new member processing and orientation.*

To schedule orientation, Clubhouse should contact:

 Applicant Phone #

 Other Name

Phone #

Applicant’s Signature

Date

*DID YOU REMEMBER TO SELECT* ***STANDARD MEMBERSHIP*** *OR*

***YOUNG ADULT TRANSITIONAL PROGRAM****?*

Please forward the completed referral form by any of the following:

**Clubhouse of Lehigh County Phone: 610-433-9910**

**1437 Gordon Street Fax: 610-433-9940**

**Allentown, PA 18102 Email: cstout@yourgoodwill.org**

**Attn: Christopher Stout, Director**