Capital Clubhouse Inc

A Mental Health Recovery Program
1517 18th Street NW, Washington, DC 20036 Phone: 202-817-9042
www.capitalclubhouseinc.org
Confidential email: amuhlbach@capitalclubhouseinc.org

Please have this referral completed or signed off by a licensed treating mental health professional who knows the individual referred. We also require a current Diagnostic Assessment. The completed form can be emailed to the above email address. After receipt of the completed referral, the new member will be contacted about attending an orientation/information session.

To be completed by a professional who has access to individual's psychiatric records:

REFERRED INDIVIDUAL'S NAME: _____

Address_____

Email: _____ Phone: _____

DOB: _____ SSN: _____

REFERRAL SOURCE DATA

How long known: _____

Name: _____ Agency: _____

Email: _____ Phone: _____

REASON FOR REFERRAL:

- ☐ ADL Support
- ☐ Education
- ☐ Employment
- ☐ Other _____
- ☐ Symptom Management Skills
- ☐ Social Skills

Clubhouse is an active team environment. Does this individual get along well with others? ___ Yes ___No
Please provide us with additional information about this person that will assist in their recovery process:

_____

_____

PLEASE NOTE: Clubhouse services are not appropriate for individuals who exhibit any of the following:

- Behaviors which threaten and/or pose a current health and safety risk to themselves or others
- Behaviors that disrupt the daily work of the Clubhouse
- Behaviors that require excessive redirection and/or monitoring
- A severity of symptoms requiring a more intensive level of treatment

My client does not exhibit any of the above behaviors/needs. Initial Here_____

Do you feel that your client can engage in a Clubhouse whose policies include: zero tolerance for drugs and alcohol on the premises, non-violence, appropriate communication, and respect for others? __ Yes __ Not at this time

PROSPECTIVE MEMBER INFORMATION

Income & Benefits

Amount: _____ and Source:

- ☐ SSI/SSDI
- ☐ VA Benefits
- ☐ Retirement Benefits
- ☐ Other: _____

Mode of Transportation:

- ☐ Public Transportation
- ☐ Walk
- ☐ Ride Share (e.g.Uber) / Cab
- ☐ Medical Transpo / Metro Access
- ☐ Other _____

Insurance: Receive DC Medicaid? __YES __NO DC Medicaid Number: _____

Name of Insurance: _____

Member's Psychiatrist/Mental Health Prescribing Practitioner:

Name: _____ Agency: _____

Email: _____ Phone: _____

Psychiatric Diagnosis(es):

- ☐ Anxiety Disorder
- ☐ Bipolar I Disorder
- ☐ Bipolar II Disorder
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia Disorder
- ☐ Major Depressive Disorder (Specify Mild, Moderate, Severe) _____
- ☐ Post Traumatic Stress Disorder
- ☐ *Personality Disorder (Specify) _____
- ☐ Other (Please specify): _____

*Individuals with PD have difficulty with the community setting of Clubhouse and may not be an appropriate referral.

Substance Use Disorder

___ Yes ___ No Drug of choice: _____

Stage of recovery: _____

Current Mental Health Treatment

- ☐ individual therapy
- ☐ group therapy
- ☐ psychoeducation groups
- ☐ medication management

Current Medications: _____

(Please attach list if more space is needed.)

Member's Core Service Agency: _____

Point of Contact: Name: _____ Phone/Email: _____

Capital Clubhouse is currently not accepting individuals in ACT services.

Person Completing this Form: _____ Phone: _____

By signing below, I certify that all information on this form is true and correct to the best of my knowledge.

Signature of licensed mental health professional: _____

Print Name _____ Date_____

CONFIDENTIAL

Prospective Member Applicant

Release of Information Form

I hereby give consent for the release of pertinent medical, hospital and psychological information from medical and/or mental health professionals associated with my care with (**provider name**:)

_____

for completion of appropriate referral information for my application for membership to the Capital Clubhouse. I also understand that if I am to become a member of Capital Clubhouse that **my Goal/Treatment Plan/Plan of Care will be updated to reflect that**. I understand that any information released to the Capital Clubhouse is confidential and will be remain confidential by the Capital Clubhouse.

Name of Prospective Member: _____

Signature: _____ Date: _____

Received By: _____ Date: _____