Capital Clubhouse Inc

REFERRAL FORM

REFERRING PROVIDER How long known: _____
Person Completing this Form: _____ Phone: _____
Agency or Housing Program: _____ Email: _____

REFERRED INDIVIDUAL'S NAME: _____ DOB: _____

Address:_____

Email: _____ Phone: _____ Alt. Phone: _____

COVID Vaccination: __YES __NO ***Please understand we require all members to be fully vaccinated for COVID.****
Medicaid? __YES __NO If Yes, DC Medicaid #: _____ MCO: _____

REASON FOR REFERRAL (please check all that apply):

___Independent Living Skills
___Therapeutic Socialization Skills
___Mental Illness Management
___Employment Support
___Prevent Psychiatric Hospitalization
___Prevocational Training
___Develop Recovery Plan
___Improve Self-Confidence/Motivation
___Interpersonal Skills
___Reduce Negative Symptoms
___Prevent Isolation
___Managing Symptoms that interfere with Education or Employment
___ Improve Cognitive/Concentration Skills
___Other _____

Does the individual have a history of violent behavior? __Yes __No; If Yes, Explain: _____
_____
Does the individual have a history of suicide attempts? __Yes __No; If Yes, When?_____
Does the individual have a history of alcohol and drug abuse and/or sexual misconduct? __Yes __No;
If Yes, Explain: _____
Has the individual been convicted of a felony? __Yes __No; If Yes, What/when: _____

MEMBER'S MENTAL HEALTH TREATMENT PROVIDER:
Name: _____ Agency: _____
Email: _____ Phone: _____

PSYCHIATRIC DIAGNOSIS(ES): ***Please attach current diagnostic assessment.****
_____
_____

MEMBER'S Core Service Agency (if applicable): _____
Point of Contact: Name: _____ Phone/Email: _____
Capital Clubhouse is currently not accepting individuals in ACT services.

SEND REFERRAL TO: amuhlbach@capitalclubhouseinc.org; Phone: 202-817-9042
1517 18th Street NW Washington, DC 20036
www.capitalclubhouseinc.org

Capital Clubhouse Inc

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: _____