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 by a licensed treating mental health professional who knows the prospective member. We also require a current Diagnostic Assessment. The completed form can be emailed to the above email address using "Encrypt" in the subject line or other form of protection. 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: _____

Agency Address: _____ Email: _____

Phone: _____

REASON FOR REFERRAL: _____

_____

_____

_____

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 Source: _____ Monthly amount: _____
How Member will get to/from Clubhouse: _____ Approximate Transportation Cost: _____
Primary Insurance: _____ Receive DC Medicaid? __YES __NO
DC Medicaid Number: _____

Member's Psychiatrist/Mental Health Prescribing Practitioner:

_____
Agency:_____
Address:_____ Phone: _____

Member's Core Service Agency: _____
CSA Point of Contact: Name: _____ Phone/Email: _____
Level of Community Support receiving and from where: _____
If in ACT, please list expected date/plan of step down to Community Support: _____
_____

Member's Primary Care Provider: _____
Agency:_____
Address_____ Phone: _____

Primary Psychiatric Diagnosis _____
Secondary Psychiatric Diagnosis including any SUD _____
_____
Other Diagnoses_____
_____
Substance Abuse History
_____ _____
_____
Is prospective member in recovery? _____
Current Mental Health Treatment Receiving (if any): _____
Current Medications: _____

Allergies/Other Medical/Physical Issues or Communication Issues That May Affect Member's Participation
In the Program? __YES __NO Please Explain:
_____
_____

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:)

_____

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: _____