Capital Clubhouse Inc

A Mental Health Recovery Program
1313 New York Ave, NW, Washington, DC 20005 Phone: 202-308-9690
www.capitalclubhouseinc.org
Confidential email: amuhlbach@capitalclubhouseinc.org

Prospective members and those who refer them are always welcome to visit Capital Clubhouse. Prospective members may bring the completed referral form with them or the referral may be sent ahead by the referring clinician. Membership is free and attendance is entirely up to the member. If you would like to speak with the Program Director (Amy), please call us during clubhouse hours. Prospective members are encouraged to visit before they join. Please call ahead if you would like to visit us, so that we can be ready to welcome you.

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

NEW MEMBER DATA

Name:

_____

Email:

_____

Address:

_____

_____

Phone:

_____

DOB: SSN:

_____ _____

REFERRAL SOURCE DATA

Name:

_____

Agency:

_____

Agency Address:

_____

_____

Email:

_____

Phone:

_____

Income Source: _____ Monthly amount: _____

Receive DC Medicaid? __YES __NO DC Medicaid Number: _____

Member's Psychiatrist/Mental Health Prescribing Practitioner:

_____
Agency:_____
Address_____
_____ Phone_____

Member's Primary Care Provider:

_____

Agency:_____

Address_____

_____ Phone_____

Axis 1 Psychiatric Diagnosis_____

Axis 2 Psychiatric Diagnosis_____

Secondary Diagnoses_____

_____

Current Treatment Receiving (if any): _____

Current Medications: _____

Substance Abuse History

_____

_____

Is prospective member in recovery? _____

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

_____

_____

Please provide us with additional information about this person that will assist in their recovery process:

_____

_____

PLEASE NOTE: Clubhouse services are <u>not</u> 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 <u>not</u> 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

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_____

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 for completion of appropriate referral information for my application for membership to the Capital Clubhouse. 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: _____