1265 S. Main St, Ste 101
Seattle, WA 98144
206.501.3730 (phone)
206.501.3733 (fax)
www.seattleclubhouse.org

Seattle CLUBHOUSE
A program of HERO House NW

To: _____
MENTAL HEALTH PROVIDER, AGENCY

From: _____
MEMBER / CLIENT

_____
DATE OF BIRTH SSN OR GOVT. ID PHONE#

_____
ADDRESS

Re: Membership at Seattle Clubhouse

I have identified a desire to join Seattle Clubhouse. I hereby request that a referral be made to Seattle Clubhouse for my membership and participation in the clubhouse as part of my recovery plan. Please include Clubhouse Services in my Individual Service Plan (ISP) as an intervention that will be of benefit to me.

_____
MEMBER/ CLIENT SIGNATURE DATE

Membership Referral

This following information is to be completed by Psychiatrist / Mental Health Care Provider:

_____
DATE OF LAST HOSPITALIZATION* NAME OF FACILITY

Precipitating Factors: _____

Mental Health Diagnosis: _____ _____
Use ICD-10 F codes (e.g., F43.1 PTSD)

Current Medications: _____

Reason for Referral / Goals: _____

Does prospective member have a history of violent behavior?	Yes	No
Has there been any legal involvement?	Yes	No
Does prospective member have a history / risk of suicide attempts?	Yes	No
Does prospective member have a history of alcohol / drug abuse?	Yes	No
Does prospective member have access to independent transportation?	Yes	No

If you answered "yes" to any of the above, indicate dates, behaviors, precipitants, legal actions and other pertinent details.

_____

_____

Additional Comments: _____

This request has been received and Clubhouse Services will be incorporated in the Client (Member) ISP

_____
NAME OF MENTAL HEALTH CARE PROVIDER: NAME OF REFERING AGENCY

_____
SIGNATURE OF MENTAL HEALTH CARE PROVIDER: DATE: