Clubhouse Referral Form (Psychosocial Rehabilitation Services)

Referral Source Name | Agency | Phone Number | Date

Member Demographic Information:

Last Name | First Name | Middle Name | Social Security Number

Date of Birth | ( ) Cell phone | ( ) Home phone

Street Address

City | State | Zip Code | County

Medicaid # | Medicare # | Other Insurance Number

Medical Providers Information:

Primary Care:

Name | Agency/Practice | Phone number

Psychiatric Care:

Name | Agency/Practice | Phone number

Therapist:

Name | Agency/Practice | Phone number

Pharmacy:

Name Agency/Practice Phone number

Diagnosis:

Code Description

Code Description

Code Description

Code Description

History:

Hospitalizations (include dates, durations, reason and location, harmful behaviors towards self/others):

Education:

Legal:

Medical (Include any physical disabilities, medical assisting devices that are needed, etc):

Abuse (Include any verbal, physical, emotional or sexual abuse):

Member needs:

Social (building positive relationships, communicating with others, preventing social isolation):

Psychiatric (utilizing coping skills, identifying triggers, attending appointments):

Physical wellness (nutrition education, participating in wellness activities, drug/alcohol/tobacco cessation):

Vocational (include employment history and any interest in employment):

Educational (literacy, ABE, GED, associates and bachelor level):

Independent Living Skills (cooking, cleaning, budgeting, home maintenance, decision making):

Other Information:

Does the member have a valid driver's license and able to drive? Y / N

Is the member their own legal guardian? Y / N

If not, who is their legal guardian and what is their relationship? If DSS is involved, what is the history?

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_____

_____

Does the member have a payee? Y / N Contact info:_____

Does the member have CST services? Y / N

Is the member going to group therapy in the community? Y / N

If so, how long have they been attending and where?

_____

_____

_____

Is there stable housing in place? Y / N

If not, what are the circumstances?

_____

_____

Is the member compliant with treatment? Y / N

Needed Paperwork:

- Comprehensive Clinical Assessment
    - Within 30 days including clinician signature or a CCA within 1 year with an Addendum within 30 days with clinician signature.
    - Primary diagnosis of mental illness is required to qualify for Thrive Clubhouse PSR program, this excludes Substance Use and Intellectual or Developmental disorders
- Person Centered Plan if involved with Community Support Team with Signature page including physician signature as well as Comprehensive Crisis Plan (Thrive PSR needs to be involved in one of the PCP goals and has 1560 PSR units per 3 months)
- Current Medication List
- Guardianship Paperwork if applicable