Clubhouse Referral Form (Psychosocial Rehabilitation Services)

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Referral Source Name | Agency | Phone Number | Date

Member Demographic Information:

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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:

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Code Description

____

Code Description

____

Code Description

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Code Description

History:

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

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Education:____

Criminal Justice Involvement:____

____

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

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____

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

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Member needs:

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

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

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

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

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____

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

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

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Other Information:

Does the member have a valid driver's license and ability 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?

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Is there stable housing in place? Y / N

If not, what are the circumstances?

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Is the member compliant with treatment? Y / N

Needed Paperwork:

- Comprehensive Clinical Assessment
  - Within 30 days with clinician signature or a one-page addendum within the last 30 days recommending PSR services.
  - 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 (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