

12838 SE 40th Place
Bellevue, WA
425.614.1282
425.614.1294 fax
www.bellevueclubhouse.org



To: _____
MENTAL HEALTH PROVIDER, AGENCY

From: _____
MEMBER / CLIENT

DATE OF BIRTH SSN OR GOVT. ID PHONE#

ADDRESS

Re: Membership at Bellevue Clubhouse

I have identified a desire to join Bellevue Clubhouse. I hereby request that a referral be made to Bellevue 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: _____

Current Medications: _____

Reason for Referral / Goals: _____

Does member have a history of violent behavior? Yes No

Has there been any legal involvement? Yes No

Does member have a history / risk of suicide attempts? Yes No

Does member have a history of alcohol / drug abuse? Yes No

Does 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:

CONFIDENTIAL