RIVERSIDE COMMUNITY CARE CLUBHOUSE REFERRAL/PROVIDER FORM

Prospective Member:								Date Initiated:	
DOB:		Gender Identity: <Select Gender>							
Address:									
City:		State:		Zip:		Telephone:			

Part One – Referral/Provider Source Information							
Name:		Role:					
Address:							
City:		State:		Zip:		Telephone:	

Part Two – Prospective Member Mental Health Information	
DIAGNOSES	
Code	Description

Most Recent Hospitalization (include where, dates and precipitant):

Other Current Supports (for example - therapist, prescriber, medications):

Stressors We Should be Aware of:

Describe Alcohol/Drug Use (include history and current situation, person's awareness of substance use disorder if applicable):

Risk Assessment (please check all that apply and provide details below)

		History	Current
1	Suicidal or Self Injurious Behavior	☐	☐
2	Physical Violence Toward Others	☐	☐
3	Verbally Abusive Toward Others	☐	☐
4	Sexual Assault Behaviors	☐	☐
5	Fire Starting Behaviors	☐	☐
6	Criminal Activities/Legal Concerns	☐	☐
7	Victimized	☐	☐
8	Other	☐	☐

Risk #:	
Risk #:	
Risk #:	
Risk #:	

Does individual have a crisis/risk plan? ☐ Yes ☐ No If yes, please include.

Does the individual have the ability to handle conflict with others in the community? ☐ Yes ☐ No

If No, please indicate supports needed or recommendation for engagement:

Please describe how the individual's mental health challenges interfere with or limits one or more major life activities:

Please describe potential goals and/or aspirations:

Part Three

Referral/Provider Signature:		Date:

Part Four – Clubhouse Use Only

Individual Meets Clubhouse Services Membership Criteria	☐ Yes	☐ No
Clubhouse Director Signature:		Date:

Revised on 10/18/23, Revised on 1/31/24 – This form fulfills DMH requirements for contract and billing.