Hillsgrove Clubhouse Referral

PLEASE PRINT

Prospective Member: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: ____________________ Cell: ____________________

Email: ____________________

Date of Birth: ____________________

Insurance: ____________________

Referring Agency or Individual: ____________________

Contact Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: ____________________ Fax: ____________________

Email: ____________________

Relationship to Prospective Member: ____________________

Reason for Referral (Please be specific and discuss issues of wellness, employment, social networking, and recovery): ____________________

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Please Complete Second Page

Name of prospective member: ____________________

Axis One Psychiatric Diagnosis: ____

ICD9 Code(required)

Axis Two Secondary Diagnosis: ____

ICD9 Code(required)

Medications:____

____

Current Treatment, Rehabilitation, or Day Programs____

Previous Treatment, Rehabilitation, or Day Programs____

Substance Abuse History:____

____

Previous Psychiatric/Hospitalization History:____

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____

Vocational/Educational History;____

____

Current Living Situation:____

Medical Restrictions and Allergies:____

Is individual a risk to self or others? (if yes, please explain):

____

____

Has individual ever been incarcerated? (if yes, please explain):

____

____

Case Manager:______________________ Phone:______________________

Physician/Prescriber:______________________ Phone:______________________

Psychiatrist:______________________ Phone:______________________

Therapist:______________________ Phone:______________________

Supervisor:______________________ Phone:______________________

Signature of Referral Source: ______________________ Date:____________

Referral reviewed by:______________________ Date:____________

 Please mail to Hillsgrove Clubhouse, 70 Minnesota Avenue, Warwick, RI 02888 or fax 401-738-7265