NEW DAY CLUBHOUSE

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Referral Form

Name:_____ Client ID # *(if applicable)*:_____

Address:_____ Phone #:_____

_____ Social Security#:_____

_____ Date of Birth:_____

Insurance Information: Medicaid #_____ Medicare #:_____

Other Insurance:_____
Company Name Address

Living Situation (circle one): Alone With Parent(s) Spouse Children Friends
Other:_____

Principal Diagnosis:_____

Secondary Diagnosis:_____

Other Medical Diagnoses:_____

Medications *(Name, Dose, Frequency)*:_____

_____

_____

Psychiatric Hospitalizations *(Hospitals, Dates, Length of Stay):*_____

_____

_____

Rate living skill competencies in the following areas:

(1) Does not need assistance; (2) Needs some assistance; (3) Needs ongoing assistance

_____Community living competencies (self-care, cooking, money management, personal grooming, maintenance of living environment)
_____Social and interpersonal competencies (conversational competency, developing and/or maintaining a positive self-image, ability to maintain positive relationships)
_____Personal adjustment competencies (ability to handle life experiences/crises, stress management, leisure time management, coping with symptoms of mental illness)
_____Cognitive and adult role competencies (able to develop/maintain cognitive abilities, adult role functioning such as increased attention, improved concentration, enhancing ability to learn, establish to ability to develop empathy
_____Prevocational activities (positive work habits, meaningful activities and/or employment, time management, prioritizing tasks, taking direction, following policies/rules and procedures, problem solving/conflict resolution, building appropriate relationships with co-workers and persons of authority, on-task behavior and task completion skills)

Other Psychosocial Treatment Needs:_____

_____

History of medication compliance: ( ) Excellent ( ) Good ( ) Fair ( ) Poor
How does client behave when off medications?_____

Currently uses alcohol/drugs? ( ) yes ( ) no If yes, explain:_____

_____

Compliance with treatment plan: ( ) Excellent ( ) Good ( ) Fair ( ) Poor
Comments:_____

Behavioral Concerns/Comments:_____

_____

_____

Please list all services provided to this referral during the past twelve months:_____

_____

_____

Interpretive Summary (*last 90 days*):_____

_____

_____

_____

_____

_____

Other Comments:_____

_____

_____

_____

Primary Psychiatrist:_____ _____
Signature Printed

Therapist:_____ _____
Signature Printed

Agency:_____ Phone #:_____

Address:_____

_____

**Please send the following (if applicable) along with the referral form:

_____ last hospital discharge

_____ Progress notes (2-3 notes)

_____ Doctor/Nurse assessment

_____ RBHS form (signed in the last 14 days)