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

Bellevue CLUBHOUSE
A program of HERO House NW

To: _____
MENTAL HEALTH PROVIDER, AGENCY

From: _____
MEMBER / CLIENT

_____
DATE OF BIRTH SSN OR GOVT. ID PHONE#

_____
ADDRESS

Re: Membership at HERO House

I have identified a desire to join HERO House. I hereby request that a referral be made to HERO House 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: