Tradewinds Clubhouse
309 Main Street, Southbridge, MA 01550
Phone: (508)765-9947   Fax: (508)764-7208
***Please return to fax # above if faxing.**

Acknowledgement of Referral
And Release of Information

Focus of Tradewinds Clubhouse:
Tradewinds Clubhouse is designed to create restorative environments in which the individuals who experience the ups and downs of mental health conditions can be assisted to achieve or regain the self-confidence and skills necessary to obtain employment and the overall quality of life.

The central focus of the Clubhouse is on work and the underlying message is one of expectation. We strongly believe that people with mental health conditions can work, contribute to our society, and make a difference in the world.

Tradewinds Clubhouse help adults with mental health conditions to add structure to their day, gain social skills, and encourage and assist members to enter the working world.

Acknowledgement and Release of Information:
I understand the focus of Tradewinds Clubhouse. The reason for my referral has been explained to me and I am interested in becoming a member.

In addition, I agree to the release of any relevant information or other data to Tradewinds for the purpose of assessing my eligibility to become a member. I also understand that communication between Tradewinds and the source of referral will occur to maximize my success.

APPLICANT: ______________________________ ______________________________
(Print name) (Signature)

REFERRAL SOURCE: ____
(Agency)

______________________________ ______________________________
(Print name) (Signature)

DATE OF REFERRAL: ____

CLUBHOUSE SERVICES REFERRAL FORM

Tradewinds Clubhouse **Date Submitted**: ____________________

APPLICANT

Name: ________________________________ Date of Birth: ____________________

Marital Status: ___________ Ethnicity: ______________ Gender Identity:__________________

Race: (Please check)

☐Am. Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Black Hispanic
☐Pacific Islander/Hawaiian ☐White Hispanic ☐White Non-Hispanic ☐Two or More Races
☐Chooses to Not Identify ☐Unknown

Language Preference: ________________________________

Address: __________________________City: _____________State: _____ Zip: _________

Phone: Home#:_________________________Cell#:_______________________________

Social Security #: ______-_____-_______ Client ID# (DMH only): ______________________

E-mail Address: ____

MassHealth/Primary Insurance: ________________________#:_______________________

REFFERING PERSON AND/OR AGENCY

Name: ______________________________________Title: ________________________

Relationship to Individual: ____

Name of Agency: ________________________________Phone #: ____________________

Fax #: _______________________Address: ______________________________________

City: _______________________State: ______________________Zip: _______________

CURRENT PROVIDERS (Are you working with any of the following?) PLEASE CHECK OFF.

☐DMH Case Manager: ___________________________Phone #:________________________

☐Mass Rehab Worker: ___________________________Phone #:________________________

☐Psychiatrist: _______________________ Agency: ____________Phone #:_______________

☐Therapist: ________________________ Agency: ____________ Phone #: ______________

☐ACCS/Open Sky: __________________ Case Worker: ____________ Phone #: _______________

☐Other: _________________________ Agency: ____________ Phone #:_______________

EMERGENCY CONTACT (Please try to give a number different from your own.)

Name: _________________________________ Best Contact Phone #: _________________

Address _______________________________________Relationship:______________________

Do you have a guardian or legal representative? ________

If yes, name and phone #? ____

LIVING ARRANGEMENT (Please specify name of program/agency where applicable)

Alone ___________ Family___________ Residential Program__________ Shelter_________

Transitional __________ Nursing Home __________Homeless ___________ Rest Home______

Supervised Apartment ____________ Other ________________________________

PSYCHIATRIC HISTORY

Record of Hospitalization (please attach additional sheets if necessary)

Last admission first

____Dates: _________________

____Dates: _________________

____Dates: _________________

What factors precipitate a crisis for this individual?

____

Date of Diagnosis:_________________________ Clinician:________________________________

CODE:	DIAGNOSIS:

Person Certifying That This Information Is Accurate:

__________________________________ __________________________________

Signature Title & Professional Degree

CURRENT MEDICATIONS AND DOSAGES

MEDICATION	DOSAGE	MEDICATION	DOSAGE	MEDICATION	DOSAGE

Current Prescribing Physician(s):

Psychiatrist: ________________________Facility: _______________________ Phone #:__________________

PCP: ________________________________Facility: _______________________ Phone #:__________________

Other:______________________________Facility:_________________________Phone#:___________________

What are applicant's feelings about medications? ____

Is there a Roger's Order in place? ___________________

Any other disabling conditions or physical limitations the applicant may have that may require reasonable accommodations? (Including allergic reactions, chronic illness, medical concerns)____

____

____

Has this person had or currently have a substance abuse/alcohol problem? ☐ Yes ☐ No

Please describe last usage:____

LEGAL HISTORY

	RECENT ARREST
	PAST ARREST
	REGISTERED SEX OFFENDER
	ON PROBATION
	ON PAROLE

DESCRIBE:____

____

____

Please check any significant behavior(s) applicant has exhibited:

☐Physical Aggression ☐Verbal Aggression ☐Suicidal Ideation/Attempts ☐Homicidal Ideation

☐Self-Harm ☐Inappropriate Sexualized Behavior ☐Fire-Setting

☐Other:____

____

____

Please attach or describe below any successful treatment approaches or crisis plans to be used with this individual:

___

___

___

INCOME & BENEFITS:

Y/N	BENEFIT	AMOUNT	Y/N	BENEFIT	AMOUNT	Y/N	BENEFIT
	SSI			FUEL ASSISTANCE			PRIVATE INSURANCE
	SSDI			EARNED INCOME			MASS HEALTH
	CHILD SUPPORT			UNEMPLOYMENT			MEDICARE
	VETERAN'S BENEFITS			GENERAL RELIEF			SECTION 8
	SNAP			OTHER INCOME			HOUSING

EMPLOYMENT HISTORY (Check only one of the options below):

☐Employed Full Time (35+ hours) ☐Part Time (Less than 35 Hours) ☐Unemployed ☐Self Employed

☐Active Military ☐Volunteer ☐Never Employed ☐Not in Labor Force ☐Retired ☐Unknown

Do you currently have a Ticket to Work? ☐ Yes ☐ No

Do you have any questions regarding your benefits (SSDI, SSI, SNAP, etc.?) ☐ Yes ☐ No

EDUCATIONAL BACKGROUND: Highest Level of Education Completed:

	UP TO GRADE 8		ASSOCIATE'S DEGREE
	SOME HIGH SCHOOL		BACHELOR'S DEGREE
	HIGH SCHOOL DIPLOMA		MASTER'S DEGREE
	CERTIFICATE PROGRAM		TRADE SCHOOL
	SOME COLLEGE		OTHER:

TRANSPORTATION

Please describe the form(s) of transportation that applicant has access to:

☐Own Car ☐Bus ☐Family ☐Outreach/Program Staff ☐None ☐Other________________

FAMILY INFORMATION

ARE YOU A PARENT? ☐ YES ☐ NO

☐ CUSTODIAL ☐ NON-CUSTODIAL W/VISITATION ☐ OTHER

MISCELLANEOUS

ARE YOU A REGISTERED VOTER?	☐ YES	☐ NO
DO YOU HAVE A STATE I.D.?	☐ YES	☐ NO
DO YOU HAVE A VALID DRIVER'S LICENSE?	☐ YES	☐ NO
DO YOU HAVE A SOCIAL SECURITY CARD?	☐ YES	☐ NO

RECOMMENDATIONS FOR SERVICES

Briefly describe applicant's short-term employment/educational goals (3-6 months):

____
____
____

Briefly describe applicant's long-term employment/educational goals (12 months)

____
____
____

OTHER RELEVANT INFORMATION

____
____
____

Please include a summary of applicant's treatment plan, IAP as well as intake summaries and most recent comp assessment/report.

Thank you,

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