ACTS Clubhouse

REFERRAL FORM

201 E. Yukon Street
Tampa, FL 33604
Telephone: 813-557-5670
E-mail: clubhouse@actsfl.org

Membership Requirements:
1. Referral Form
2. Most Recent Psychiatric Evaluation (Please Attach)

REFERRAL INFORMATION

Referred By: _____ **Agency**: _____ **Date**: _____

Address: _____ **Telephone**: _____ **Fax**: _____

Email: _____ **Physician/Clinician Signature (Optional)**: _____

PROSPECTIVE MEMBER INFORMATION

Name: _____ **Date of Birth:** _____ **Social Security Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Telephone: _____ **Alternate Number:** _____

Medicaid: ☐ **Yes** ☐ **No** **If Yes, Medicaid #:** _____

DIAGNOSIS

Primary DX:	
Secondary DX:	
GAF Score (if known):	
Traumatic Brain Injury	☐ yes ☐ no
Autism Spectrum Disorder	☐ yes ☐ no
Developmental or Intellectual Disability	☐ yes ☐ no

Current Medications (or attach list): _____

Date of Last Hospitalization: _____ **Where?** _____ **Reason:** _____

PSYCHIATRIST INFORMATION

Please fill out completely.

Name of Psychiatrist: _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Telephone: _____ **Fax:** _____

DEMOGRAPHIC INFORMATION

Living Situation: ☐ Homeless ☐ Lives with Relatives/Caregivers ☐ Group Home ☐ Independent

Employed? ☐Yes ☐No If Yes, Where/When/How Long? _____

Source of Income: _____

Income Amount/Month: $ _____

RISK ASSESSMENT

BEHAVIOR	HISTORY	CURRENT ACTIVITY LEVEL
violence	☐ yes ☐ no	☐ none ☐ minimal ☐ moderate ☐ high
suicide attempt(s)	☐ yes ☐ no	☐ none ☐ minimal ☐ moderate ☐ high
alcohol/drug use	☐ yes ☐ no	☐ none ☐ minimal ☐ moderate ☐ high
sexual exploitation	☐ yes ☐ no	☐ none ☐ minimal ☐ moderate ☐ high

Describe any legal involvement, violence, sexual exploitation, or substance use:

_____

_____

REASONS/GOALS FOR REFERRAL

Please check all that apply:

☐ Basic Living Skills
☐ Develop Recovery Plan
☐ Improve Self-Confidence/Motivation
☐ Therapeutic Socialization Skills
☐ Interpersonal Skills
☐ Improve Motivation
☐ Employment Support
☐ Reduce Negative Symptoms
☐ Prevent Isolation
☐ Independent Living Support
☐ Mental Illness Management
☐ Improve Cognition/Concentration
☐ Training
☐ Prevent Psychiatric Hospitalization
☐ Other (Please specify): _____

Additional Comments:

(use additional paper, if necessary, for any aspect of this referral form)