



Westwinds Clubhouse

545 Westminster Street
Fitchburg, MA 01420
Tel: 978-345-1581
Fax: 978-665-0006
E-Mail: westwinds@communityhealthlink.org
Website: www.westwindsclubhouse.org

Referral Form: Please Print

To be completed and signed by a professional provider who has access to individual's psychiatric records.

New Member Data

Name: _____

Address: _____

Telephone: _____

Sex: Male Female (please check)

E-Mail: _____

D.O.B.: _____

Social Security: _____

Masshealth Policy#: _____

Language Preference: _____

Does Member have transportation: Yes / No

Referral Source

Name: _____

Agency: _____

Address: _____

Telephone: _____

Today's Date: ____ / ____ / ____

Reasons for Referral (Check all that apply):

- _____ Education Services
- _____ Housing Supports
- _____ Employment Services
- _____ Young Adult Program
- _____ Life Skills

- _____ Community Linkage (Mental Health Services, Medical/Dental Care, Social Security Benefits, And other Community Resources specific to Recovery goals)
- _____ Health and Wellness

DIAGNOSIS INFORMATION:

Axis I
Axis II
Axis III
Axis IV
Axis V

Who diagnosed prospective member with Axis I diagnosis? _____

Date of that diagnosis? _____

HISTORY:

Previous Psychiatric History and Hospitalizations: _____

Is individual a risk to others (if yes, please explain): _____

Has individual ever been in jail or on probation, if yes why: _____

SERVICE PROVIDERS:

DMH Case Manager: _____ Phone: _____
Physician: _____ Phone: _____
Psychiatrist: _____ Phone: _____
Therapist: _____ Phone: _____
MA Rehab Commission: _____ Phone: _____
C.B.F.S. Worker: _____ Phone: _____
P.A.C.T. Worker: _____ Phone: _____

PHYSICAL HANDICAPS: (Please Check *One* or *More* of the Options Below):

Description	Description	Description
<input type="checkbox"/> Blind, Legally <20/200	<input type="checkbox"/> Hard of Hearing, Impaired	<input type="checkbox"/> Semi-Ambulatory, Cane/Crutch
<input type="checkbox"/> Blind, Total Loss of Vision	<input type="checkbox"/> Medical Condition Serious / Chronic	<input type="checkbox"/> Other Impairment Not Listed
<input type="checkbox"/> Deaf, Severe to Profound	<input type="checkbox"/> Non-Ambulatory, Wheelchair	<input type="checkbox"/> None

LIVING ARRANGEMENT: Living Arrangement is defined as the person's primary place of residence (Check only One of the options below):

Description	Description	Description
<input type="checkbox"/> Lives Alone	<input type="checkbox"/> Group Living Environment	<input type="checkbox"/> Nursing Home/Skilled Nursing Fac.
<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Inpatient Facility	<input type="checkbox"/> Rest Home
<input type="checkbox"/> C/A Comm. Based Res.	<input type="checkbox"/> Jail/Correctional Facility	<input type="checkbox"/> Homeless Shelter
<input type="checkbox"/> C/A Residential School	<input type="checkbox"/> Lives with Minor	<input type="checkbox"/> Lives on the Street
<input type="checkbox"/> C/A Residential Treatment	<input type="checkbox"/> Lives with Non-Relatives	<input type="checkbox"/> Temporary Living
<input type="checkbox"/> Foster Home	<input type="checkbox"/> Lives with Adult Relatives	<input type="checkbox"/> Unknown/Unavailable

EMPLOYMENT STATUS: (Please Check Only One of the Options Below):

Description	Description	Description
<input type="checkbox"/> Active Military Duty	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Unemployed (<i>History of Employment</i>)
<input type="checkbox"/> Full Time (35 Hours or More)	<input type="checkbox"/> Transitional Employment	<input type="checkbox"/> Never Employed
<input type="checkbox"/> Part Time (Less than 35 Hours)	<input type="checkbox"/> Volunteer Only	<input type="checkbox"/> Not in Labor Force
<input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Unknown

ETHNICITY: Ethnicity is defined as the group of people who you are connected to by a common national origin, history, language or customs and cultural experiences. (Please Check *Only One* of the Options Below):

Description	Description	Description	Description
<input type="checkbox"/> Albanian	<input type="checkbox"/> Eritrean	<input type="checkbox"/> Israeli	<input type="checkbox"/> Portuguese
<input type="checkbox"/> American	<input type="checkbox"/> Ethiopian	<input type="checkbox"/> Italian	<input type="checkbox"/> Puerto Rican
<input type="checkbox"/> Armenian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Japanese	<input type="checkbox"/> Russian
<input type="checkbox"/> Bosnian	<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Salvadoran
<input type="checkbox"/> Brazilian	<input type="checkbox"/> German	<input type="checkbox"/> Laotian	<input type="checkbox"/> Somali
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Greek	<input type="checkbox"/> Lebanese	<input type="checkbox"/> Thai
<input type="checkbox"/> Canadian	<input type="checkbox"/> Guatemalan	<input type="checkbox"/> Mexican	<input type="checkbox"/> Tibetan
<input type="checkbox"/> Cape Verdean	<input type="checkbox"/> Haitian	<input type="checkbox"/> Moroccan	<input type="checkbox"/> Ukrainian
<input type="checkbox"/> Chinese	<input type="checkbox"/> Hmong	<input type="checkbox"/> Nicaraguan	<input type="checkbox"/> Venezuelan
<input type="checkbox"/> Columbian	<input type="checkbox"/> Honduran	<input type="checkbox"/> Nigerian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Congolese	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> West Indian/Caribbean
<input type="checkbox"/> Costa Rican	<input type="checkbox"/> Iranian	<input type="checkbox"/> Panamanian	<input type="checkbox"/> Two or More
<input type="checkbox"/> Dominican	<input type="checkbox"/> Iraq	<input type="checkbox"/> Peruvian	<input type="checkbox"/> Chooses Not to Identify
<input type="checkbox"/> Egyptian	<input type="checkbox"/> Irish	<input type="checkbox"/> Polish	<input type="checkbox"/> Other

RACE: The following designations come from the federal government: (Please Check *Only One* of the Options Below):

Description	Description	Description
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Black/Hispanic	<input type="checkbox"/> White/Non-Hispanic
<input type="checkbox"/> Asian	<input type="checkbox"/> Pacific Islander/Hawaiian	<input type="checkbox"/> Two or More
<input type="checkbox"/> Black OR African American	<input type="checkbox"/> White/Hispanic	<input type="checkbox"/> Chooses to Not Identify

EMERGENCY CONTACT OR LEGALLY AUTHORIZED REPRESENTATIVE:

Name: _____ Phone: _____

Relationship: _____

Address: _____



Signature of Prospective Member

Signature of Referral Source