Westwinds Clubhouse

545 Westminster Street
Fitchburg, MA 01420
Tel: 978-345-1581
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E-Mail: westwinds@communityhealthlink.org
Website: www.communityhealthlink.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 O Female O (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**
☐	Blind, Legally <20/200	☐	Hard of Hearing, Impaired	☐	Semi-Ambulatory, Cane/Crutch
☐	Blind, Total Loss of Vision	☐	Medical Condition Serious / Chronic	☐	Other Impairment Not Listed
☐	Deaf, Severe to Profound	☐	Non-Ambulatory, Wheelchair	☐	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**
☐	Lives Alone	☐	Group Living Environment	☐	Nursing Home/Skilled Nursing Fac.
☐	Assisted Living	☐	Inpatient Facility	☐	Rest Home
☐	C/A Comm. Based Res.	☐	Jail/Correctional Facility	☐	Homeless Shelter
☐	C/A Residential School	☐	Lives with Minor	☐	Lives on the Street
☐	C/A Residential Treatment	☐	Lives with Non-Relatives	☐	Temporary Living
☐	Foster Home	☐	Lives with Adult Relatives	☐	Unknown/Unavailable

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

	Description		**Description**		**Description**
☐	Active Military Duty	☐	Supported Employment	☐	Unemployed *(History of Employment*
☐	Full Time (35 Hours or More)	☐	Transitional Employment	☐	Never Employed
☐	Part Time (Less than 35 Hours)	☐	Volunteer Only	☐	Not in Labor Force
☐	Self Employed	☐	Retired	☐	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
☐	Albanian	☐	Eritrean	☐	Israeli	☐	Portuguese
☐	American	☐	Ethiopian	☐	Italian	☐	Puerto Rican
☐	Armenian	☐	Filipino	☐	Japanese	☐	Russian
☐	Bosnian	☐	French	☐	Korean	☐	Salvadoran
☐	Brazilian	☐	German	☐	Laotian	☐	Somali
☐	Cambodian	☐	Greek	☐	Lebanese	☐	Thai
☐	Canadian	☐	Guatemalan	☐	Mexican	☐	Tibetan
☐	Cape Verdean	☐	Haitian	☐	Moroccan	☐	Ukrainian
☐	Chinese	☐	Hmong	☐	Nicaraguan	☐	Venezuelan
☐	Columbian	☐	Honduran	☐	Nigerian	☐	Vietnamese
☐	Congolese	☐	Indian	☐	Pakistani	☐	West Indian/Caribbean
☐	Costa Rican	☐	Iranian	☐	Panamanian	☐	Two or More
☐	Dominican	☐	Iraq	☐	Peruvian	☐	Chooses Not to Identify
☐	Egyptian	☐	Irish	☐	Polish	☐	Other

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

	Description		Description		Description
☐	American Indian/Alaska Native	☐	Black/Hispanic	☐	White/Non-Hispanic
☐	Asian	☐	Pacific Islander/Hawaiian	☐	Two or More
☐	Black OR African American	☐	White/Hispanic	☐	Chooses to Not Identify

EMERGENCY CONTACT OR LEGALLY AUTHORIZED REPRESENTATIVE:

Name: ______________________________ Phone: ______________

Relationship: ____

Address: ____

____
Signature of Prospective Member

____
Signature of Referral Source