

Thunderbird Clubhouse Referral Form

Demographics

Prospective Member's Name _____ Date of Referral _____

Maiden Name _____

Address _____

Telephone # _____

County _____

Social Security # _____

Date of Birth _____ Age _____ Marital Status: Married _____ Divorced _____ Never Married _____

of People Contributing to Income _____ # of People Dependent on Income _____

Living Situation? Alone With Family/Relatives With Non-Related Persons

Annual Income: _____

Veteran Status: Yes No

Race: White Black or African American American Indian or Alaskan Native

Native Hawaiian or Pacific Islander Asian Other Choose not to Specify

Psychiatric History

Diagnoses

Medications

Current LOF: _____

CAR Scores: Feeling Mood _____ Thinking _____ Substance Use _____ Med/Phys _____
Family _____ Interpersonal _____ Role Perf. _____ Socio-Legal _____
Self Care _____

Current Mental Health Service Provider

Name [Doctor/Social Worker] _____ Agency _____

Address _____

Phone # _____

History of Previous Hospitalizations [number, precipitating events, etc.]

Most recent hospitalization _____

Substance Abuse History

Drugs Yes No

Alcohol Yes No

Tobacco Yes No

Other Yes No [specify: _____]

Describe history of use/what substance or drug of choice/treatment/usual route of administration/
frequency of use in last 30 days/age first used/sober time:

Violent/Criminal History

Legal/Criminal History Yes No

History of Violence Yes No

Has Individual been arrested in the last 30 days? Yes No Last 12 months? Yes No

Describe history, include dates and action taken:

Probation? Yes No

Prison? Yes No

Felony? Yes No

Convictions? Yes No

Educational History

Level of Education completed: _____

Education History: (successes, goals set but not achieved, etc.)

Employment History

Currently Employed? Yes No

If Yes, Part-Time or Full-Time? _____

Last 12 months? _____

Total Years Employed _____

Total # of jobs: _____

Additional Vocational History: _____

Current Daily Activity: _____

Medical Information

Medical Alerts or Physical Disability _____

Primary Family Doctor _____

Address and Phone: _____

Referred by _____

Agency _____

Phone Number _____

Medicare: Yes No

Medicaid: Yes No

SSI: Yes No

SSDI: Yes No

How did you hear about Thunderbird Clubhouse? _____

What are your specific goals with Clubhouse? _____

**PLEASE DO NOT FAX REFERRALS.
PLEASE MAIL ALL REFERRALS TO P.O. BOX 1666 NORMAN, OK 73070.**