Miracle Clubhouse

Referral Form

Goodwill easterseals Miami Valley

Referred By:_____ Telephone :_____ Date: _____

Referral Agency:_____

Comments:_____

******A Full Diagnostic Assessment (DA) or A Diagnostic Assessment Update (DAU) within the last year is required.***
******Please attach documentation to this referral.***

Referral's Name: _____

DOB: _____ Age:_____ (*must be at least 18yrs*) SSN: _____-_____-_____

Address: _____

Telephone #: _____ Alternate #: _____

Living Situation: ___Homeless ___Lives with Relatives ___Group Home ___Independent

Employed? ____Yes____ No If Yes, Where? _____How Long?_____

Source of Income: _____ Amount: _____

Method of Transportation: _____

Do this individual have Medicaid: ○Yes ○No Insurance Provider: _____

Date of Last Hospitalization for Mental Health: _____
Where? _____

Mental Health Diagnosis: _____

Reason for Referral (Please check all that apply):

_____ Socialization Skills _____Interpersonal Skills _____Prevent Psychiatric Hospitalization
_____ Employment Support _____Prevent Isolation _____Improve self-confidence/motivation
_____ Improve cognitive/concentration skills _____Independent Living Support
_____Managing Symptoms that interfere with education or employment
_____Other:_____

Is there a history of substance abuse, violent behavior, or suicide attempts?
Please explain: _____

_____

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