



# REFERRAL FORM FOR THE ROC CLUBHOUSE

"REACHING OUR COMMUNITY"

Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ SSN: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Home Ph: ( ) \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Parent DFCS Other: \_\_\_\_\_

**Insurance:** Indigent/Self-Pay Medicaid Private: \_\_\_\_\_

Medicaid/Insurance Number: \_\_\_\_\_

**Living Situation:** Priv. Residence Shelter Correctional Facility Foster Care Group Home Other: \_\_\_\_\_

**Caregiver Resources:** Inability to meet basic needs of youth Potentially dangerous environment Impairment in CG judgment-functioning CG hostile/rejecting towards youth Alleged/actual abuse in home Domestic violence Parental illegal activities

**Referring Agency:** COURT DFACS DJJ SCHOOL OTHER \_\_\_\_\_

Contact Person: \_\_\_\_\_ Ph: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_ Ph: \_\_\_\_\_

Caseworker: \_\_\_\_\_ Ph: \_\_\_\_\_

Fax: \_\_\_\_\_

**Presenting Circumstances:** (i.e., recent episode of behaviors/symptoms that require services at this time):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Services within the past year:** Psychiatric Individual Counseling Family Counseling Group Counseling  
Day Services Substance Abuse Intensive Family Therapy Community Support Other: \_\_\_\_\_

**Has the child had a Biopsychosocial completed?** Yes No **If yes, please attach to referral**

**Education:** School: \_\_\_\_\_ Grade: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact: \_\_\_\_\_

Regular Classroom EBD/Psychoeducation Special education Alternative School

**Currently:** Active Suspended Expelled

**Signature of Referring Person:** \_\_\_\_\_ Phone: \_\_\_\_\_

Clubhouse Program Manager email: [ivetteellis@highlanddrivers.org](mailto:ivetteellis@highlanddrivers.org)

