210 E. Michigan St., Milwaukee WI, 53202
Tel: 414-727-3366
Fax: 414-276-1606
Email: membership@grandavenueclub.org

Referral Form

(Please Print)

New Member Data

Name: ____________________________

Address: __________________________

____

____

Tel: ______________________________

Email: ____________________________

DOB: _____________________________

Referral Source

Name: _____________________________

Agency: ____________________________

Address: ___________________________

____

____

Tel: _______________________________

Today's Date: ______________________

Note: To be completed by a licensed provider who has access to individual's psychiatric records. Please fill out form and send it to Grand Avenue Club via fax or email.

Please complete using diagnostic names:

Personality Disorder (s)

____

Primary Mental Health Dx(s)

____

Secondary Mental Health Dx(s)

____

Significant/Relevant Medical Dx(s)

____

How long have you known/been working with this applicant?

____

What do you hope the applicant will get out of Grand Avenue Club?

____

Please complete part 2

Please Print

Name of prospective member ____

Please answer all of the questions. They are vital to understanding if the individual is eligible for membership.

Has Rx Tx been recommended? YES NO Has Therapy been recommended YES NO

Is the individual medication compliant? YES NO N/A Are they attending therapy YES NO N/A

Is this individual capable of interacting with others in a community in a positive manner? YES NO

Is this individual a threat to their safety or to the safety of others? YES NO

Any Comments or Concerns:

Case Manager (if applies): ___________________________ Phone: ________________________________

Psychiatrist:____ Phone: ________________________________

Therapist: ____ Phone: _________________________________

Provider signature:_______________________________Provider Credentials:________________Date:__________