CONFIDENTIAL

B'MORE CLUBHOUSE

New Member Information Form

Last Name First Name MI

Street Address Apt.

City State Zip Code

Home Phone # Cell Phone # Email Address

Date of Birth: ___/____/____ **Personal Pronouns (please specify):** _____

Gender Identity: __Female __Male __Transgender __Nonbinary/other __Decline to answer

Marital Status:
____ Single
____ Married
____ Domestic Partnership
____ Divorced
____ Other

Residence Status:
____ Alone
____ Family
____ Transitional Housing
____ Group Home
____ Shelter
____ Other:_____

Ethnicity: (Optional)
____White/Caucasian
____ Black/African American
____ Latino/Hispanic
____ Asian
____ Native Hawaiian or Other Pacific Islander
____ American Indian
____ Other:_____

How did you hear about us?
_____
_____

Psychiatrist/Mental Health Professional:

Name: _____

Phone:_____

Medical Doctor:

Name: _____

Phone:_____

Emergency Contact Person:

Name: _____ Relationship:_____

Phone:_____

CONFIDENTIAL

B'MORE CLUBHOUSE
REFERRAL FORM

*THIS FORM MUST BE FILLED OUT AND SIGNED BY A LICENSED MENTAL HEALTH PROFESSIONAL
PLEASE ATTACH THE MOST RECENT CLINICAL ASSESSMENT TO THIS REFERRAL

Referred by:_____Agency:_____

Address: _____ Phone: _____ Fax: _____

Psychiatrist Name: _____ Phone: _____ Fax: _____

Client Name: _____ DOB: _____

Address: _____Phone: _____

Living Situation: _____ Stable: _____ Unstable: (please describe) _____
_____

Date of Last Hospitalization: _____Where?_____

Precipitating Factors: _____
_____

Does the individual have Medicaid? Y / N Medicaid #: _____

Diagnosis:
Axis I _____
Axis II _____
Axis III _____

Current Medications:
_____ _____
_____ _____
_____ _____

Does he/she have a history of violent behavior? If yes, please explain:
_____
_____

Does he/she have a history of suicide attempts? If yes, please explain:
_____
_____

Does he/she have a history of alcohol and/or drug abuse? If yes, please explain:
_____
_____

Additional comments:
_____
_____

_____
Signature Title Date

Please return this form to: Theresa Bell, Program Coordinator – Membership

B'More Clubhouse, 9 E. Franklin St., Baltimore, MD 21202
Phone: 410-727-2030; Fax: 410-727-2034; Web: www.bmoreclubhouse.org

CONFIDENTIAL

B'More Clubhouse

Prospective Member Applicant

Release of Information Form

I hereby give consent for the release of pertinent medical, hospital and psychological information from medical and/or mental health professionals associated with my care for completion of appropriate referral information for my application for membership to the B'More Clubhouse. I hereby give consent for B'More Clubhouse members to have access to my basic contact information for follow-up and reach-out purposes only.

I understand that any information released to the B'More Clubhouse is confidential and will be remain confidential by the B'More Clubhouse.

Name of Prospective Member: _____

Signature: _____ Date: _____

Received By: _____ Date: _____

Audio/Visual Release (Optional)

I hereby give consent to B'More Clubhouse to use my photograph, voice, and likeness to be used in any B'More Clubhouse publication including, but not limited to, its website.

Signature: _____ Date: _____