The Key Clubhouse
Rebuilding Lives
9000 SW 137th Ave, Suite 220 Miami, FL 33186
Tel: 786-504-4374 Fax: 786-949-0354

Referral Form

Prospective Member Information

Name: _____ Date of Birth: _____

Address : _____ SSN: _____/_____/_____

City: _____ State: _____ Zip: _____ Tel: (_____) _____

Diagnosis	Medications

Medicaid Recipient? ❑ NO ❑ YES, if yes: HMO: _____
(Name of HMO)

Reason for Referral/Goals: _____

Risk Assessment		
Behavior	History	Current Activity Level
Violence	❑ NO ❑ YES	❑ None ❑ Minimal ❑ Moderate ❑ High
Suicide Attempt(s)	❑ NO ❑ YES	❑ None ❑ Minimal ❑ Moderate ❑ High
Alcohol/Drug Abuse	❑ NO ❑ YES	❑ None ❑ Minimal ❑ Moderate ❑ High
Sexual Exploitation	❑ NO ❑ YES	❑ None ❑ Minimal ❑ Moderate ❑ High

Psychiatrist/Licensed Clinician Information — Please Fill Out Completely

Name: _____ Date: _____

Address: _____ Tel: (_____) _____

City: _____ State: _____ Zip: _____

License: _____ Occupation: _____

Signature: _____