

# Membership Referral



14230 NE 21st Street  
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425.614.1282  
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www.herohouse.org

Date of Referral: \_\_\_\_\_ Referred By: \_\_\_\_\_

Referring Agency: \_\_\_\_\_

Member's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Medicaid:  Yes  No King County ID# \_\_\_\_\_

Date of Last Hospitalization:\* \_\_\_\_\_ Where: \_\_\_\_\_

Precipitating Factors:\* \_\_\_\_\_

Diagnosis:\* \_\_\_\_\_ Current Medications: \_\_\_\_\_

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Reason for Referral/Goals:\* \_\_\_\_\_

Does member have a history of violent behavior?\*  Yes  No

(If Yes, please explain): \_\_\_\_\_

Any legal involvement?\*  Yes  No

(If Yes, please explain): \_\_\_\_\_

Does member have a history/risk of suicide attempts?\*  Yes  No

(If Yes, please explain): \_\_\_\_\_

Does member have a history of alcohol or drug abuse?\*  Yes  No

(If Yes, please explain): \_\_\_\_\_

Does member have access to independent transportation?  Yes  No

(If Yes, please explain): \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Mental Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**\*MUST BE COMPLETED BY PSYCHIATRIST/MENTAL HEALTH CARE PROVIDER/DVR COUNSELOR**