

# Goddard Riverside

## TOP Clubhouse

263 W 86<sup>th</sup> St, New York, NY 10024

(212) 799-7171

## REFERRAL FORM

Email To: Lois Powell

Date: \_\_\_\_\_

LPowell@goddard.org

Name of person being referred: \_\_\_\_\_

Telephone number of person being referred: \_\_\_\_\_

***\*Referred individuals must have a history of mental illness and be age 18 or older***

*I give permission to my healthcare or other service provider to give my name, contact information, and protected health information to TOP Clubhouse. I understand that a TOP Clubhouse staff person will contact me to provide more information about the Clubhouse and schedule a tour. I understand that my name, contact information and other information listed below will not be disclosed or shared with any other entity unless authorization is obtained by me. I understand that I can revoke my permission at any time by contacting the referring provider named below. I give permission to TOP Clubhouse to follow up with the individual or provider named below.*

Signature \_\_\_\_\_

Date \_\_\_\_\_

***\*must be signature of person being referred***

- Providers who have received verbal consent from the individual being referred should check this box to attest to having received this consent in lieu of obtaining a signature.

### TO BE COMPLETED BY REFERRING PROVIDER

Provider Name: \_\_\_\_\_

Provider Organization: \_\_\_\_\_

Provider Phone: \_\_\_\_\_

Provider Email: \_\_\_\_\_