Goddard Riverside

TOP Clubhouse

263 W 86th St, New York, NY 10024
(212) 799-7171

REFERRAL FORM

Email To: topofficecenter@goddard.org **Date: _____**

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: _____