

Saol Clubhouse – EVE (HSE) Application Form for Membership



Note:

- **To become a member one must:**
 - Have a primary diagnosis of mental ill health
 - Be aged between 18 and 65 years
 - Have access to support from an appropriate mental health professional
 - Be free from alcohol and drug misuse
 - Be willing and able to take part in the day to day activities of clubhouse
 - At the time of application, be free from acute mental distress
 - Be living in the community, or if in hospital, have a definite discharge plan
- The person applying for membership should complete all relevant sections of the form and supply it to the club. The club will then pass it on to the person's relevant mental health professional e.g. Psychiatrist, Community Mental Health Nurse, Social Worker for final completion. Disclosure of sensitive information does not necessarily mean that you / the applicant will not be eligible for membership.
- For ease of reading, please fill this form using BLOCK LETTERS.
- All sections of this form and any additional information required must be completed / submitted before it can be processed.
- It is **strongly recommended** that potential members visit the Clubhouse for a guided tour and explanation of the model prior to applying for membership.
- Clubhouse has control over its acceptance of new members.

Personal Details																	
<p>Mr / Mrs / Ms (Please Circle One)</p> <p>Name: _____</p> <p>Address: _____ _____ _____</p> <p>Date of Birth: ____ / ____ / ____</p> <p>Phone No.: _____</p> <p>Mobile No.: _____</p> <p>P.P.S. No.: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table></p> <p>Medical Card No.: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table></p>																	<p>What Clinic/Service are you in contact with?</p> <p>_____</p> <p>Address: _____ _____ _____</p> <p>Phone No.: _____</p> <p>Who is your Consultant / G.P.?</p> <p>_____</p> <p>Who is your Key-worker (e.g. Community Mental Health Nurse, Social Worker etc.)?</p> <p>_____</p> <p>Psychiatric Diagnosis:</p> <p>_____</p> <p>Is there any additional information/medical condition pertinent to this application?</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Next of Kin or person to contact in emergency:</p> <p>Name: _____</p> <p>Address: _____ _____ _____</p> <p>Phone No.: _____</p>																	

Personal Details (contd.)

This section of the application form must be completed in full by the appropriate mental health professional

Does this person have a history of:

	Yes	No
Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate Sexual Behaviour	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Behaviour	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol / Drug Misuse	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive / Violent Behaviour	<input type="checkbox"/>	<input type="checkbox"/>
Criminal Record	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please provide *specific* details:

Signature of Referrer: _____ Date: _____
 _____ (Print Name)

Personal Needs

Why do you want to become a member of Clubhouse?

Do you currently have any hopes or dreams for the future? (Please describe)

Have you ever attended any other E.V.E. services? (If so, where?)

Authorisation

I wish to apply to Clubhouse for membership and give permission that relevant information/reports may be requested for this purpose. I also authorise the storage of such information and/or reports on a computer database and/or manual filing system to be maintained by the Clubhouse on the basis that it will be stored in accordance with the Data Protection Acts 1988 and 2003.

Signed: _____

Date: _____

For office use only

Date of initial visit: ____ / ____ / ____ Date completed form received: ____ / ____ / ____

Confirmation:

Date: ____ / ____ / ____ Time: _____ Referrer: _____ Staff Member: _____

Issues arising: Yes No Outcome: Offered Declined Deferred

Date of orientation: ____ / ____ / ____ to ____ / ____ / ____ Completed: Yes No

A.O.B. _____