



**clubhouse**  
MIDWEST BRAIN INJURY

## Member Referral

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

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

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

Telephone: \_\_\_\_\_

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

Contact Name (if different than above): \_\_\_\_\_

Purpose of Referral: \_\_\_\_\_

Clubhouse Programs (Stroke & Acquired Brain Injury for Adults 16-70 yrs old)

Referral Made By: \_\_\_\_\_

Hospital or Facility: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Estimated Discharge Date: \_\_\_\_\_

*I give permission to release this information to the Midwest Brain Injury Clubhouse*

**Please send referral to:**  
**Midwest Brain Injury Clubhouse**  
**300 N. Elizabeth St. Suite 310-C**  
**Chicago, IL 60607**

**Fax: 312-226-8722**

**Telephone: 312-226-8720**