UCSF CITYWIDE EMPLOYMENT PROGRAM
SFGH Vocational Rehabilitation

SLICE OF LIFE CAFÉ & CATERING

Slice of Life Culinary Training Program Application

Client Name:		**DOB:**
Primary Language:	**Ethnicity:**	**Gender:**
Address:	**City:**	**Zip:**
Phone:	**Email:**	
Primary Care Clinic:	**Primary Care Doctor/Nurse:**	
Case Manager/Therapist:	**CM Phone:**	**CM Email:**
Agency:	**Agency Contact #:**	

I authorize my diagnosis/clinical information be released/exchanged by the referring source to Citywide Employment Program

CLIENT'S SIGNATURE: _____ *DATE:* _____

CLINICAL SECTION: *This section must be completed by a licensed clinician.*

Pertinent History / Hospitalizations _____

Current Treatment/Medication(s) _____

_____

Current mental status (symptoms)?	*Frustration tolerance?*
Ability to accept constructive feedback?	*Concentration/learning ability?*
Situations to Avoid/Triggers?	*Assaultive/violent history?*
Strengths:	*Judgment?*

Mental Health Primary Diagnosis (es) _____ BIS # _____

Comments: _____

_____

Referred by: (name & credential) _____ *Signature* _____

**Co-Signature: (if applicable)* *Signature* _____

Agency/Address _____ *Phone* _____ *Date* _____

* **Co-signer must have one of these professional credentials: LPCC, MFT, NP, RN, LCSW, MD, PsyD, or PhD (In Psychology).**

Please send completed form: FAX 628-206-8942 or email: CW_SOL@LISTSRV.UCSF.EDU