Adult Intensive Services Referral Form
Information & Instructions

PRIVATE & CONFIDENTIAL

HERE 24 SEVEN

1 844 437 3247 (HERE247)

Call anytime to access Addictions, Mental Health & Crisis Services Waterloo-Wellington

Date:	Name of Individual:	CID:

If you have any questions about the referral process, please call Here24/7 for assistance.
Please fax **complete** referral to Here 24/7: 1-844-437-3329
Incomplete referrals will not be processed and will be returned

Client / Patient Information:

Name: _____
Date of Birth: _____
Health Card: _____
Version: _____ Expire: _____
Gender: _____

Address: _____
Phone #: _____
Please confirm confidential messages can be left:
☐ Yes ☐ No Details: _____
Email: _____
Preferred Language: _____

Emergency Contact Info:

Name: _____
Relationship: _____
Phone #: _____

About the Referral:

Referral Status: _____
Is your client aware of the referral? ☐ Yes ☐ No
Details: _____

Community Treatment Order:
☐ Yes ☐ No ☐ Pending

Monitoring Psychiatrist: _____
Phone #: _____

SDM: _____
Phone #: _____

Renewal Date: _____

Referral Source Information:

Name: _____
Select Referral Source:
☐ Family GP ☐ Psychiatrist ☐ Nurse Practitioner
☐ Other: _____

Phone #: _____
Fax #: _____
Billing #: _____

Physician Contact Information:

Physician: _____
Is Physician aware of referral? ☐ Yes ☐ No
Phone #: _____
Billing #: _____

Pharmacy Information:

Pharmacy: _____
Location: _____
Phone #: _____

Current Psychiatrist Information:

Psychiatrist: _____
Phone #: _____

Community Supports / Involvement:

Please list community contacts:

Name: _____
Relationship: _____
Phone #: _____

Name: _____
Relationship: _____
Phone #: _____

Fax: 1-844-437-3329 **www.here247.ca**

80 Waterloo Ave.
Guelph, ON
N1H A01

67 King St. E
Kitchener, ON
N2G 2K4

3-9 Wellington St.
Cambridge, ON
N1R 3Y4

St. Patrick St. E
Fergus, ON
N1M 1M6

1 Blue Springs Dr. Suite 100
Waterloo, ON
N2J 4M1

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1. Reason for Referral: *(e.g. Goals for treatment, presenting problems, impact on functioning, current symptoms)*

2. Substance Use: *(e.g. current substance, amount, frequency, stage of change, previous treatment experience)*

3. Risk Concerns:

Risk	Check	If Yes, when?	Details
Suicidal Ideation/plan/intent	☐Yes ☐No ☐Unknown		
Harm to self and/or neglect	☐Yes ☐No ☐Unknown		
Threat to others	☐Yes ☐No ☐Unknown		
Legal Involvement	☐Yes ☐No ☐Unknown		
Violent Behaviour	☐Yes ☐No ☐Unknown		
Fire Setting	☐Yes ☐No ☐Unknown		
Workplace Violence	☐Yes ☐No ☐Unknown		
Access to Weapons	☐Yes ☐No ☐Unknown If yes, please explain:		
Other *(please specify)*			

4. Medications: *(Psychiatric and non-psychiatric – attach Pharmacy List)*

Are there any allergies to be aware of? ☐Yes ☐No ☐Unaware
If yes, please specify:

Medication	Dose	Frequency	Prescribed By	Prescribed Date	Administered By	Compliance
						☐ Yes ☐ No ☐ Unknown
						☐ Yes ☐ No ☐ Unknown
						☐ Yes ☐ No ☐ Unknown
						☐ Yes ☐ No ☐ Unknown
						☐ Yes ☐ No ☐ Unknown

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5. Hospitalization: *(Please describe hospitalizations and Emergency Department within the last two years – include all relevant documentation – attach discharge summaries)*

Dates (admit to discharge)	Facility	Presenting Issues	Discharge Diagnosis

7. Barriers to Treatment: *(Insight, transient, medical complexities, previous treatment, etc.)*

8. Supports & Resources:

Type	Details
Family	
Housing	
Income	
Other	

9. Supporting Documentation: ***(Incomplete referrals may be returned)***

- ☐ Discharge Summaries
- ☐ Medication Record
- ☐ Consents: Client/SDM/Partner
- ☐ Psychological Assessment
- ☐ Legal Information
- ☐ Forensic Assessment(s)
- ☐ Summary of Involvement
- ☐ Developmental/ABI Report(s)
- ☐ Other:

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Completed by: **Position:**

Intake Only – Internal Use Only

Referral Package Reviewed: Reviewed by: Complete: ☐Yes ☐No

Next Steps:

CC: **Client Family:** **Date:**
Referral Source / GP: **Date:**
Other: **Date:**

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