|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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:** |  |  | **Referral Source Information:** |  |
| Name: |       |  |  | Name: |       |  |
| Date of Birth: |       |  |  | Select Referral Source: |  |
| Health Card: |       |  |  | [ ]  Family GP | [ ]  Psychiatrist | [ ]  Nurse Practitioner |  |
| Version: |       | Expire: |       |  |  | [ ]  Other: |       |  |
| Gender: |       |  |  |  |  |
| Marital Status: |       |  |  | Phone #: |       |  |
| # of Dependents: |       |  |  | Fax #: |       |  |
| Age of Dependents: |       |  |  | Billing #: |       |  |
|  |  |  |  |  |
| Address: |       |  |  | **Physician Contact Information:** |  |
| Phone #: |       |  |  | Physician: |       |  |
| Please confirm confidential messages can be left: |  |  | Is Physician aware of referral? | [ ]  Yes [ ]  No |  |
|  [ ]  Yes [ ]  No Details: |       |  |  | Phone #: |       |  |
| Email: |       |  |  | Billing #: |       |  |
| Preferred Language: |       |  |  |  |  |
|  |  |  |  | **Pharmacy Information:** |  |
| **Capacity to Consent to Treatment:** | [ ]  Yes [ ]  No  |  |  | Pharmacy: |       |  |
| **Capacity to Management Property:** | [ ]  Yes [ ]  No  |  |  | Location: |       |  |
|  |  |  | Phone #: |       |  |
| **Emergency Contact Info:** |  |  |  |  |  |
| Name: |       |  |  | **Current Psychiatrist Information:** |  |
| Relationship: |       |  |  | Psychiatrist: |       |  |
| Phone #: |       |  |  | Phone #: |       |  |
|  |  |  |  |  |
| **About the Referral:** |  |  | **Community Supports / Involvement:** |  |
| Referral Status: |       |  |  | Please list community contacts: |  |
| Is your client aware of the referral? | [ ]  Yes [ ]  No |  |  |  |  |
| Details: |       |  |  | Name: |       |  |
|  |  |  |  | Relationship: |       |  |
| Community Treatment Order: | [ ]  Yes [ ]  No [ ]  Pending |  |  | Phone #: |       |  |
|  |  |  |  |  |
| Monitoring Psychiatrist: |       |  |  | Name: |       |  |
| Phone #: |       |  |  | Relationship: |       |  |
|  |  |  | Phone #: |       |  |
| SDM: |       |  |  |  |  |  |
| Phone #: |       |  |  |  |  |  |
| Specify SDM Treatment: |       |  |  |  |  |  |
| Renewal Date: |       |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |
| --- |
| **1. Reason for Referral:** *(e.g. Goals for treatment, presenting problems, impact on functioning, current symptoms)*  |
|       |
|  |
| **2. Current Primary Diagnosis and Other Diagnosis** |
|       |
|  |
| **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 |

|  |
| --- |
| **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 |       |
| Functional Impairments |       |
| 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:  |       |
| 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** |
| **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:** |  |