|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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*** | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | | |  | | | | | | | | | |  |  |  | | |  | | | |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |

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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** | | | |
|  | | | |  | | | | | |  | | | | |  | | | |
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| **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:** | |  |