| Date of Birth | | | yy/mm/dd | | | | | Name of Individual: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | CID: | | | | |  | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| 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** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gender: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | Marital Status: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| # of dependents: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Age of dependents: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home phone: | | | | |  | | | | | | | | | Cell phone: | | | | | | | |  | | | | | | | | | | | | Email address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Health card: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | Version code: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Preferred mode of contact: | | | | | | | | | | |  | | | | | | | Home | | | |  | | | | | Cell | | | | Can we leave a message: | | | | | | | | | | | | | | | | | | | |  | | | | Yes | | | |  | | No | | | |
| Is an interpreter required: | | | | | | | | | | |  | | | | | | | Yes | | | |  | | | | | No | | | | Language: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Capacity to consent: | | | | | | | | | | |  | | | | | | Home | | | | |  | | | | | Cell | | | | Capacity to management property: | | | | | | | | | | | | | | | | | | | | |  | | | | | Yes | | |  | | No | | |
| Capacity to Consent: | | | | | | | | | | |  | | | | | | | Yes | | | |  | | | | | No | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Emergency Contact | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Phone: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | Cell Phone: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Preferred mode of contact: | | | | | | | | | | |  | | | | | | | Home | | | |  | | | | | Cell | | | | Can we leave a message: | | | | | | | | | | | | | | | | | | | |  | | | | Yes | | | |  | | No | | | |
| Is an interpreter required: | | | | | | | | | | |  | | | | | | | Yes | | | |  | | | | | No | | | | Language: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referring Source: | | | | | Family GP | | | | | | | | | | Psychiatrist | | | | | | | | | | | Nurse Practitioner | | | | | | | | | | | | Other: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contact Name: | | | | |  | | | | | | | | | | | | | | | | | | | Contact Number: | | | | | | | | | | | |  | | | | | | | | | | Contact Fax: | | | | | | | | | |  | | | | | | | | |
| Health Card #: | | | | |  | | | | | | | | | | | | | | | | | | | Version Code: | | | | | | | | | | | |  | | | | | | | | | | Billing #: | | | | | | | | | |  | | | | | | | | |
| Family Physician: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Is Physician aware of referral? | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
| Referral Status: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Is your client aware of the referral? | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
| Details: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Community Treatment Order: | | | | | | | | Yes  No  Pending | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Monitoring psychiatrist: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Specify SDM treatment: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Renewal Date: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Physician Contact Information: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physician name: | | | | |  | | | | | | | | | | | | | | | | | | | | Contact Number: | | | | | | | | | | | |  | | | | | | | | | | Contact Fax: | | | | | | | | | | |  | | | | | | | | | |
| 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: | | | | | | | | | | |  | | | | | | | | | |
| Name: | | | | |  | | | | | | | | | | | | | | | | | | | | Relationship | | | | | | | | | | | |  | | | | | | | | | | Phone: | | | | | | | | | | |  | | | | | | | | | |
| 1. **Reason for Referral:** *(e.g., Goals for treatment, presenting problems, impact on functioning, current symptoms)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **Current Primary Diagnosis and Other Diagnosis** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **Substance Use:** *(e.g., current substance, amount, frequency, stage of change, previous treatment experience)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **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)* | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **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 | | | | | | | | | | | |
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| 1. **Hospitalization:** *(Please describe hospitalizations and Emergency Department within the last two years – include all relevant documentation – attach discharge summaries)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Dates  (admit to discharge) | | | | | | Facility | | | | | | | | | | | | | | | Presenting Issues | | | | | | | | | | | | | | | | | | | | | Discharge Diagnosis | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **7. Barriers to Treatment:***(Insight, transient, medical complexities, previous treatment, etc.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Intake Only – Internal Use Only*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referral Package Reviewed: | | | | | | | | | |  | | | | | | | | | | Reviewed by: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | Complete: Yes No | | | | | | | | | | | | | | | | | | |
| **Next Steps:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Fax your referral to Here24/7 at 1-844-437-3329 for processing during regular business hours** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CC:** | | **Client Family:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | |  | | | | | | | | | | | | | | | | |
|  | | **Referral Source / GP:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | |  | | | | | | | | | | | | | | | | |
|  | | **Other:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | |  | | | | | | | | | | | | | | | | |