| Date of Birth | yy/mm/dd | 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** |
| 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)*
 |
|       |
| 1. **Current Primary Diagnosis and Other Diagnosis**
 |
|       |
| 1. **Substance Use:** *(e.g., current substance, amount, frequency, stage of change, previous treatment experience)*
 |
|       |
| 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 |
|       |       |       |       |       |       | [ ]  Yes[ ]  No[ ]  Unknown |
|       |       |       |       |       |       | [ ]  Yes [ ]  No[ ]  Unknown |
|       |       |       |       |       |       | [ ]  Yes [ ]  No[ ]  Unknown |
|       |       |       |       |       |       | [ ]  Yes [ ]  No[ ]  Unknown |
| 1. **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:  |       |
| ***Intake Only – Internal Use Only*** |
| Referral Package Reviewed:  |        | Reviewed by:  |       | Complete: [ ] Yes [ ] No |
| **Next Steps:**  |
|       |
| **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:** |  |