Eastern Health
Mental Health and Addictions Services

INCOMPLETE FORMS WILL BE RETURNED

Referral Form

CL1190 0016 07 2012

(Please complete and return both sides)

Date of Referral: DD/MONTH/YYYY

Client Name: _____
Address: _____
_____

Home Phone	**Work Phone**	**Cell Phone**
Leave message?: ☐ Yes ☐ No	Leave message?: ☐ Yes ☐ No	Leave message?: ☐ Yes ☐ No

HCN: _____
Date of Birth _____ *(DD/MONTH/YYYY)* **or Age:** _____
Gender: ☐ **Male** ☐ **Female**
Inpatient (at time of referral?): Where: _____

Service requested: _____
Reason for referral (please be as specific as possible and include diagnosis if appropriate)? _____

Current or past mental health & addictions services used? _____

List current medications: _____

Current community supports/involvement with other services? _____

Problems with Aggressive Behaviour? ☐ Yes ☐ No
If yes, explain: _____

Is this a mandated referral? ☐ Yes ☐ No Is this for consultation only? ☐ Yes ☐ No
Is this person pregnant? ☐ Yes ☐ No Has this person served in military or RCMP ☐ Yes ☐ No
If child, is there a risk of child going into the care of Child, Youth &Family Services (CYFS)? ☐ Yes ☐ No
Please include any additional information/special considerations: _____

Is the person being referred aware of this referral? ☐ Yes ☐ No

Self Referral: ☐ **Yes** ☐ **No**

If client is a minor:
Name of Parent/Guardian: _____
Tel: _____

If not self referral, please complete the following:
Form completed by (please print):
Name: _____
Agency/Service: _____
Address: _____
Tel: _____ Fax: _____

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 32 and 33 of the *Access to Information and Protection of Privacy Act*, and will be used for processing your request for Mental Health and Addictions Services. Please direct any questions about this collection to: Privacy Officer, Eastern Health, Quality and Risk Management, 12th Floor, Southcott Hall, 777-8025.

Eastern Health

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Name:

HCN:

Date of Birth:

Mental Health and Addictions Services

Referral Form (Part II)

Please check most relevant:

- Suicidal/Homicidal Ideation
  - ☐ Plan with clear intent to die/kill **(refer immediately to emergency department)**
  - ☐ Plan with vague and/or undetermined plan
  - ☐ Recurring thoughts of suicide/homicide –no plan
  - ☐ Vague fleeting thoughts of suicide/homicide
  - ☐ No thoughts of suicide / homicide

- Acuteness / Chronicity of symptomalogy /presenting issues
  - ☐ Severe acute symptoms with impaired reality testing (e.g. Delusions, hallucinations)
  - ☐ Acute Symptoms/circumstances with significant distress
  - ☐ Acute symptoms/ circumstances with some distress
  - ☐ Ongoing symptoms /circumstances
  - ☐ Mild symptoms/circumstances with minimal distress

- Impairment in Activities of Daily Living, Social, Occupational, or School Functioning
  - ☐ Unable to maintain minimal activities of daily living
  - ☐ Not attending/functioning in social, occupational or school environment
  - ☐ Attending but having difficulty functioning at work, school, family or social situations
  - ☐ Some difficulty with day to day functioning but still participating
  - ☐ Mild difficulties but has skills to function pretty well

- Formal Supports available
  - ☐ No supports appropriate to current level of functioning
  - ☐ For continuity of care this current service is essential (next logical step)
  - ☐ Supports available - not being utilized/effective
  - ☐ Some supports
  - ☐ Adequate supports

PLEASE COMPLETE AND RETURN BOTH SIDES OF FORM

Name: _____ Date: DD/MONTH/YYYY

Signature: _____

For Office Use Only:

Date Received: DD/MONTH/YYYY

Date of Intake Commencement: _____

Urgency Classification: P1 ☐ P2 ☐ P3 ☐

Program Assigned: _____

Date Seen by Program _____

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