fraserhealth

REFERRAL FORM: Community Mental Health and Substance Use Services

A. PERSON DETAILS

*** If these cells pre-printed by Form Imprint, no need to repeat**

Title:

Surname: *

First name: *

Middle name: *

Preferred first name: Preferred surname:

Birth date: * (DD/MM/YY) Estimated? ☐ **Age:**

Address: ☐ No fixed address ☐ Homeless

City: **Province:**

Postal code: **Country:**

☐ Current address? ☐ Do not mail client **PHN: ***

Gender: * ☐ Male ☐ Female ☐ Unknown

Phone number: ☐ No phone number

Home: ☐ Primary contact # **Can we leave a message at this number?** ☐ Yes ☐ No

Other: ☐ Primary contact # **Can we leave a message at this number?** ☐ Yes ☐ No

Next of kin: **Name:** **Relationship:** **Phone #:** ☐ Can leave a msg?

First person to contact: ☐ Same as next of kin **Name:** **Relationship:** **Phone #:** ☐ Can leave a msg?

General Practitioner: ☐ None ☐ Referral CC'd to GP Phone #: Fax #:

Psychiatrist: ☐ None Phone #: Fax #:

B. REFERRAL DETAILS

Priority: ☐ 1 - Low ☐ 2 - Medium ☐ 3 - High ☐ 4 - Urgent

Referral reason *(presenting issues, symptoms of mental illness, substance use, suicide risk, priority - please attach any available history or assessments):*

Services requested / desired outcome:

Current diagnoses (if known, psychiatric and medical):

Is client aware of referral? ☐ Yes ☐ No **Is client's family aware of referral?** ☐ Yes ☐ No

If referral from hospital, actual or expected discharge date (DD/MM/YY)

Extended leave? ☐ No ☐ Yes, certificate expiry date (DD/MM/YY) **Accepting MRP:**

MHSU contacts in past 12 months: **# contacts: Inpatient services:** ☐ N/A ☐ Unknown **# contacts: Emergency Dept:** ☐ N/A ☐ Unknown

REFERRAL FORM: Community Mental Health and Substance Use Services (MHSU) Cont'd

C. REFERRER DETAILS

Referral source:

Date of referral: (DD/MM/YY)

Title:

Role:

First name:

Phone #: (incl. ext.)

Surname:

Reference: (external file #, etc.)

D. MEDICATION AND ALLERGY INFORMATION - To be completed when referral is made from health care providers (i.e., physicians, hospitals, health services, etc.)

Current medications *(including known OTCs, herbals and vitamins)*

OR: ☐ MAR **and/or** ☐ Current prescriptions **and/or** ☐ Pharmanet profile attached

Long-acting injectable medication

Name: **Dosage:** **Frequency:**

When last given (DD/MM/YY)? **When next due (DD/MM/YY)?**

Medication adherence: ☐ Not an issue ☐ Unknown ☐ Compliance issues, please specify:

Medication coverage: ☐ Self ☐ Plan G ☐ Other, please specify:

Allergies: ☐ Allergy profile attached