**Community Mental Health**

**Closing/Transfer Summary**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  |  | **DOB** |  |
| **PHIN:** |  |  |  |  |
| **Date of Referral:** |  |  | **Date:** |  |
| **Date Opened:** |  |  | **Status:** | Choose an item. |
| **Date of Admission:** |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reason for Referral** | | | | |
|  | | | | |
| **Diagnostic Impression** | | | **Confirmed or Not Confirmed** | |
|  | | | Choose an item. | |
|  | | | Choose an item. | |
|  | | | Choose an item. | |
|  | | | Choose an item. | |
| **Summary of Intervention + Outcome** | | | | |
| *Outline of therapeutic interventions, including psychiatry/psychology/other consultations completed* | | | | |
|  | | | | |
| **Reason for Transfer-Closure/Client Status on last contact (brief description, including date of last contact)** | | | | |
|  | | | | |
| **Recommendations for Re-referral to Community Mental Health Program** | | | | |
| Are there factors that are likely to be relevant to Access and CMHW from the start if the client re-refers? | | | | |
| Choose as many as applicable: | | Choose an item. | | |
|  | | Choose an item. | | |
|  | | Choose an item.  Other, please indicate in comment section | | |
|  | | | | |
| Comments: |  | | |  |
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