**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: |  |  |
|  |