Reset Form

CRISIS RESPONSE SERVICES
CRISIS STABILIZATION UNIT
REFERRAL FORM

Call Toll Free: 1-855-320-1096

Label Space

Use CARE ☐ YES ☐ NO

REFERRAL DATE (DD/MMM/YYYY): _____ TIME: _____am _____pm

CLIENT NAME: _____ _____ GENDER: _____
(FIRST NAME) (LAST NAME)

D.O.B: _____ AGE: _____ PHIN #: _____ MHSC #: _____
(DD/MMM/YYYY)

ADDRESS: _____ _____ _____ _____
(STREET#/ NAME/ BOX #) (TOWN/CITY) (PROVINCE) (POSTAL CODE)

HOME PHONE #: _____ CELL #: _____ **PERMISSION TO LEAVE VOICEMAIL?** ☐ YES ☐ NO

BEST METHOD OF CONTACT: _____

ABORIGINAL STATUS: ☐ YES ☐ NO

IS THE CLIENT AWARE AND AGREEABLE TO MENTAL HEALTH SERVICES? ☐ YES ☐ NO

NAME OF REFERRAL SOURCE: _____

☐ SELF ☐ PARENT/GUARDIAN ☐ PHYSICIAN ☐ SCHOOL _____ ☐ OTHER _____

REFERRAL SOURCE TELEPHONE #:_____ FAX #:_____

ADDRESS: _____ _____ _____ _____
(STREET#/NAME/BOX #)) (TOWN/CITY) (PROVINCE) (POSTAL CODE)

INTERPRETATION SERVICES (available, if required): ◯ Language: _____

REASON FOR REFERRAL

Section A			
CLIENTS ARE NOT SUITABLE CANDIDATES FOR THE CSU IF THE FOLLOWING ARE PRESENT:	**Yes**	**No**	**Unsure**
IS HOUSING OR SHELTER THIS INDIVIDUALS PRIMARY NEED?			
IS THIS INDIVIDUAL MEDICALLY UNSTABLE?			
IS THIS INDIVIDUAL INTOXICATED?			
DOES THIS PERSON POSE A SIGNIFICANT SAFETY RISK TO SELF AND/OR OTHERS? **(IS THERE A CLEAR INDICATION AND/OR EXPRESSED INTENTION OF ACTING ON IT?)**			

Section B	**Yes**	**No**	**Unsure**
NEEDS SUPPORT, PROBLEM SOLVING, ADVOCACY, AND REFERRAL TO MANAGE THEIR CURRENT CRISIS, SUFFICIENT TO RETURN TO THEIR REGULAR ENVIRONMENT?			
IS THE INDIVIDUAL BEING DISCHARGED FROM A HOSPITAL STAY AND WOULD BENEFIT FROM A SHORT TERM STAY AT THE CRISIS BED PROGRAM, AND TO FACILITATE THEM SUCCESSFULLY TRANSITIONING BACK INTO THE COMMUNITY?			
HAS RCMP INVOLVEMENT BEEN A RESULT OF UNSTABLE/FLUCTUATIONS OF THE ILLNESS/SYMPTOMS AND REQUIRES SHORT TERM INTENSIVE SUPPORT TO PREVENT FURTHER ENCOUNTERS WITH RCMP?			
HAS A COMBINATION OF SUBSTANCE USE AND EXPERIENCING SYMPTOMS OF MENTAL ILLNESS WHICH REQUIRES SHORT TERM OBSERVATION?			

NOTE: IF YOU HAVE ANSWERED YES TO ANY ONE OF THE QUESTIONS IN SECTION B, PROCEED AND COMPLETE THE NEXT SECTION OF THIS FORM.

NAME OF FAMILY PHYSICIAN/NP: _____ Address/Phone: _____

NAME OF PSYCHIATRIST/PSYCHOLOGIST/OTHER MENTAL HEALTH PROFESSIONAL: _____

PAST/PRESENT MEDICAL CONDITIONS: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY): _____

PAST/PRESENT MENTAL HEALTH DIAGNOSIS: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY): _____

PAST/PRESENT MEDICATIONS: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY): _____

PAST/PRESENT INVOLVEMENT WITH MENTAL HEALTH PROGRAM/COUNSELLING: ☐ YES ☐ NO

MOBILITY ISSUES: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY) _____

ALLERGIES: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY) _____

REASON FOR REFERRAL: (CHECK ALL THAT APPLY): SERVICE REQUESTED: ☐ PSYCHIATRY CONSULT ☐ THERAPY/COUNSELLING

☐ DEPRESSION	☐ CHANGES IN MOOD/BEHAVIOR	☐ SLEEP / APPETITE DISTURBANCE
☐ ANXIETY	☐ MANAGING ILLNESS	☐ SUBSTANCE USE
☐ HEARING VOICES OR SEEING THINGS	☐ UNUSAL THOUGHTS/IDEAS	☐ TRAUMA
☐ MEMORY CONCERNS	☐ RECENT LOSS / LIFE CHANGE	☐ THREATS / HARM TO OTHERS
☐ THOUGHTS TO END LIFE ☐ Recent ☐ Past	☐ SELF-HARM ☐ Recent ☐ Past	☐ OTHER_____

DIFFICULTIES WITH: (CHECK ALL THAT APPLY):

☐ FINANCES	☐ EMPLOYMENT/SCHOOL	☐ FAMILY/SOCIAL RELATIONSHIPS
☐ HOUSING	☐ MANAGING DAILY LIVING TASKS	☐ ALCOHOL/DRUGS/GAMBLING
☐ MEMORY/THINKING PROBLEMS	☐ MANAGING ILLNESS SYMPTOMS	☐ MANAGING MEDICATION

Please specify: _____

DURATION OF PROBLEM: ☐ *Under 3 months* ☐ *6-12 months* ☐ *1year+*

SIGNATURE OF PERSON COMPLETING THE REFERRAL: _____

DECLARATION OF CONSENT:

I am aware that the personal and health information could be forwarded to the Community Mental Health Program. I hereby consent to forwarding any relevant documentation by making this referral to Southern Health-Santé Sud.

_____ _____

Signature of Client Date

PLEASE INCLUDE ALL RELEVANT DOCUMENTATION (REPORTS, LETTERS, ETC.) PLEASE SEND COMPLETED FORM BY FAX TO THE CRISIS STABILIZATION UNIT @ 346-3539

******* Missing Information will delay the referral process *******

Bonjour Hello

Ce Document est aussi disponible en Francais