

Incomplete applications will not be accepted for review.

Referral Application Completed by:

Name:	Tel:
Position held:	

Referred Individual

Name:	DOB:	Gender: M [] F []
PHN:	SIN:	Ethnicity:

Landed immigrant: or Canadian Citizen?

Resource (Individuals Home or Resource)

Name:	Tel:
Address:	

Mother

Name:	Tel:
Address:	

Father

Name:	Tel:
Address:	

Legal Guardian or Committee:

Name:	Tel:
Address:	

(to be signed at the "first intake meeting")

Print name	Signature	Date:	month /day /year
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Analyst / Facilitator

Name:	Tel:
Address:	

Completed by - Print name	Signature	Date:	month /day /year
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QSM (Sign off)- Print name	Signature	Date:	month /day /year
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CLINICAL SUMMARY

Physician

Name:	Tel:
Address:	

Is the physician in agreement with the referral? Yes No
Is the care team in support of the referral? Yes No

Medical Plan: Yes No Number:

Dental Plan: Yes No Number:

REASONS FOR REFERRAL: (i.e., In-Patient Assessment, Medication Review, Stabilization of Behaviour, Mood, Sleep;
(Please give details and expectations of this referral):

Current Individual / Behavioural / Clinical Concerns:

Please list Previous In-patient Admissions / Hospitalizations if known:

APPLICATION FOR ADMISSION

Type of Admission: Voluntary: or Involuntary:
New Admission: Re-Admission:

Level of Intellectual and Social Functioning:

Other concerns which impact functioning:

Treatment Goal(s):

Placement on Discharge: (home, other, specify)

Who suggested this referral?

Is individual considered a danger to self or others? Yes No (Details)

What steps have already been undertaken to address presenting issues? (e.g. other services contacted)

PSYCHOLOGICAL ASSESSMENTS

Tests	Score

OTHER PROFESSIONAL SERVICES INVOLVED

	Name / Title :	Telephone number:
Psychiatrist		
Neurologist		
Other Medical Specialists		
Mental Health Support Team		
Primary Therapist		
Other Service Providers under MHST (i.e., Behaviour Therapist, Counselor, APG)		
Health Services for Community Living (HSCL)		
Nurse		
Nutritionist		
Occupational Therapist (OT)		
Physiotherapist (PT)		
Art or Music Therapist		
Community Support Worker (CSW)		
Community Pharmacy		

OFFICE USE ONLY

Legal Status:	Financial Responsibility of:
<input type="checkbox"/> MCFD <input type="checkbox"/> CIC <input type="checkbox"/> GUARDIAN & PUBLIC TRUSTEE	<input type="checkbox"/> BCEA – BC Employment Assistance <input type="checkbox"/> Guardian <input type="checkbox"/> Public Trustee <input type="checkbox"/> TSDM <input type="checkbox"/> Committee <input type="checkbox"/> Micro board

<input type="checkbox"/> ESTATE <input type="checkbox"/> INDIAN AFFAIRS <input type="checkbox"/> CFCS <input type="checkbox"/> MEIA <input type="checkbox"/> TSDM
