Heskw'en'scutxe
Health Services Society
Cooks Ferry • Siska Indian Bands
1-800-458-2212

MENTAL HEALTH & SUBSTANCE USE SERVICES REFERRAL FORM

DATE:_____

☐ **Urgent** ☐ **Within a Week** ☐ **Within a Month**

	Last	First	Initial	DOB	Gender
NAME					Male / Female
Address				Minor Child Yes No	
City		Postal		Emergency Contact:	
Client phone for scheduling:				Phone	Cell

Refer to:

☐ Mental Health ☐ Other:
☐ Harvey SU/A ☐ Family Counseling
☐ Vince SU/A ☐ Counseling Services ☐ Pickering, RP ☐ NLX MH

1.) Permission to call and/or leave a message? **YES** **NO**

2.) Is the client aware of this referral? **YES** **NO**

3.) Has this person been hospitalized within the past 30 days? **YES** **NO** Date: _____

4.) Reason for referral (Please include functional/behavioural changes):

_____

_____

_____

5.) Previous Diagnosis (mental health, addictions, medical):

_____

6.) List Medications: **YES** **NO**

_____

7.) Is there a suicide risk? **YES** **NO**

_____

8.) Are there any safety concerns for the client or towards workers? **YES** **NO**

(e.g. Victim of abuse/violence in a relationship, history of aggression, etc.)
If yes, please specify:

_____

_____

9.) Referral Agency/Person

_____

(Print Agency and Contact Information) Phone

PLEASE ATTACH ANY ADDITIONAL PERTINENT INFORMATION