



**ACUTE HOME BASED TREATMENT PROGRAM – RICHMOND
 Referral Form**

PLEASE NOTE EXCLUSIONARY FACTORS

- * Out of VCH/PHC Catchment Area
- * Significant Risk of Physical Aggression
- * Actively Suicidal/Homicidal
- * Client is Certified under the Mental Health Act unless being released on Extended Leave
- * Primary Diagnosis is Organic Brain Disorder
- * Primary Diagnosis is AXIS II

PATIENT INFORMATION HOSPITAL ADMIT DATE D/C DATE

Name: *Last* _____ *First* _____ Marital Status: _____ Gender ()M()F()O
 PARIS #: _____ PHN: _____ DOB: _____ Phone #: _____
 Address: _____
 Support Person: _____ Relationship to Client: _____ Phone #: _____

REFERRAL INFORMATION REFERRAL DATE

Source: _____ Phone #: _____ Fax # _____
 GP: _____ Phone #: _____ **Is Patient Supportive of Referral ()Y()N**
Community Supportive of Referral ()Y()N Support Person Aware and Supportive ()Y()N()N/A

REASON FOR REFERRAL: Presenting Problems, Diagnosis, Symptoms, Severity & Psychiatric History

Goals for Treatment: _____

INVOLVED MENTAL HEALTH TEAM/SUPPORT: Name: _____

Psychiatrist: _____ Case Mgr/Counselor: _____ Phone #: _____
 Ext. Leave: ()Y ()N Hospital: _____ Renewal Date: _____ Next Appointment: _____

CLINICAL FEATURES

Suicidality:

Ideation No Active Passive Intent
Plan No Yes _____
Attempts No One More than one
 Date of last attempt: _____
 Lethality of attempts: low mod high

Self Harm Behaviour:

Current No Yes _____
Past No Yes _____

Aggressive Behaviour:

Others none low high
Property none low high

Drug and Alcohol Use:

Type	Quantity	Frequency

Legal Charges/Involvement:

Family/Work Issues: _____

Current Housing Situation: _____

Medical Issues: _____

MEDICATION	DOSE	FREQ

- See attached med record
 - Adverse Reactions? _____
 - Allergies? _____
- Outstanding Referrals/Waitlists ()N ()Y Who?**

Please attach: 1) Clinical Notes 2) Written order for Blister packed Meds 3) D/C Med Rec 4) Documentation for Ext. Leave