

Referral Form for Treatment

Date of Referral:

Thank you for referring your patient to Homewood Health (HH). HH offers a comprehensive national continuum of care that focuses on mental health and addiction inpatient and outpatient treatment. If one of our services is outside of your patient's preferred treatment location, or you are unsure of the recommended facility for treatment, please indicate "unknown" in section 1 below and we will consult with your patient to help determine the appropriate Homewood Health location.

Section 1: Preferred Referral Location

Inpatient <input type="checkbox"/> Homewood du Plateau – Montreal, Quebec <input type="checkbox"/> Homewood Health Centre – Guelph, Ontario <input type="checkbox"/> Ravensview – Victoria, British Columbia <input type="checkbox"/> The Residence – Guelph, Ontario <input type="checkbox"/> Unknown		Outpatient <input type="checkbox"/> The Homewood Clinic – Vancouver, British Columbia <input type="checkbox"/> The Homewood Clinic – Edmonton, Alberta <input type="checkbox"/> The Homewood Clinic – Calgary, Alberta <input type="checkbox"/> The Homewood Clinic – Mississauga, Ontario	
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Section 2: Client/Patient Information

Client/Patient Name:		Gender:
Address:		City:
Province/State:	Postal/Zip Code:	Country:
Date of Birth:	Email Address:	
Home phone:	Mobile Phone:	
Current height:	Current weight:	Allergies:
Occupation:	Employer Name:	
Health Card #:	Expiry Date:	
Department of National Defense Blue Cross Service # (if applicable):		
Veterans Affairs Canada K # (if applicable):		
Workers Compensation Board # (e.g., WSIB, Worksafe BC):		

Section 3: Primary Reason for Referral

Section 4: Conditions (Check all which apply and indicate which is the primary concern)

In the last 6 months	Prior to 6 months ago	Primary Concern	In the last 6 months	Prior to 6 months ago	Primary Concern
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Acute or Chronic Psychosis <small>(Thoughts disorder/hallucination/delusion)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dissociative Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Addiction <small>(drug and/or alcohol)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PTSD, Abuse, Trauma or OSIs <small>(Occupational Stress Injuries (OSI))</small>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Anxiety Disorder <small>(Social Phobia or panic disorder)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Major Depression (Unipolar)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Autism or Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> OCD (Obsessive Compulsive Disorder)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bipolar Disorder <small>(Hypomania, mania, depression)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cognitive Disorder <small>(Head injury, memory problems)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Substance Abuse (drug and/or alcohol)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dementia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other (please describe):			

Section 11: Current Medications

1. List here or attach a list (using the format below) of all current medications and supplements:

Name	Dosage	Frequency	Reason for Use

2. Does the client/patient take prescribed opiates? (e.g., codeine, Methadone etc.) Yes No
 If yes, for pain, for addiction.

Section 12: Significant Medical History

List all applicable conditions (e.g., diabetes hypertension, etc.)

Section 13: Addiction

1. Does the patient currently have any drug or alcohol (substance) problems? Yes No *If no, skip to section 14*

First substance of choice is: _____ Years of use: _____ Amount used per day: _____

Second substance of choice is: _____ Years of use: _____ Amount used per day: _____

2. Has the patient ever experienced severe withdrawal symptoms from alcohol or drugs (e.g., DTs, psychosis, seizures or hallucinations)? Yes No *If yes, describe:*

3. Does the patient admit to having a drug or alcohol problem? No Yes

4. Is the patient currently prescribed the following medications? *Note: some programs have specific admission requirements concerning methadone treatment.*

	Dosage:	Prescribed for:	Comments:
Methadone <input type="checkbox"/> No <input type="checkbox"/> Yes	mg/day	<input type="checkbox"/> addiction treatment <input type="checkbox"/> chronic pain management	
Suboxone <input type="checkbox"/> No <input type="checkbox"/> Yes	mg/day	<input type="checkbox"/> addiction treatment <input type="checkbox"/> chronic pain management	

5. Is the client/ patient using medical marijuana? Yes No *Comments:*

6. Does the client/patient use nicotine? Yes No *Comments:*

Please note, all inpatient facilities are tobacco free

Section 14 (if applicable):

If you are referring to the **Eating Disorders Program at Homewood Health Centre** additional information will be needed. Forms will be forwarded to the patient.

If you are referring for **Traumatic Stress Recovery**, please indicate all the types of trauma the client/patient has experienced:

Violence Accident Occupational Military Childhood Other:

Thank you for your referral to Homewood Health