



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 | Outpatient |
| <input type="checkbox"/> Homewood Health Centre – Guelph, Ontario | <input type="checkbox"/> The Homewood Clinic – Vancouver, British Columbia |
| <input type="checkbox"/> Ravensview – Victoria, British Columbia | <input type="checkbox"/> The Homewood Clinic – Edmonton, Alberta |
| <input type="checkbox"/> The Residence – Guelph, Ontario | <input type="checkbox"/> The Homewood Clinic – Calgary, Alberta |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> The Homewood Clinic – Mississauga, Ontario |

Section 1a. Recovery Management ('aftercare') through Homewood

| | | |
|---|------------------------------|-----------------------------|
| I am interested in learning about Homewood delivered Recovery Management post-inpatient treatment that may be available in my province/territory. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|

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): | | |
| Room Accommodation: <input type="checkbox"/> Semi-Private <input type="checkbox"/> Private <i>Note, assigned accommodation is based on funder/referring agency approval.</i> | | |

Section 3: Primary Reason for Referral & Return to Work Goal (if applicable)

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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 (Thoughts disorder/hallucination/delusion) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dissociative Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Addiction (drug and/or alcohol) | <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 (Occupational Stress Injuries (OSI)) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety Disorder (Social Phobia or panic disorder) | <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 (Hypomania, mania, depression) | <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 (Head injury, memory problems) | <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 5: Current Safety Risks (Check all which apply)

| | |
|---|--|
| <input type="checkbox"/> Current active suicidal thoughts | <input type="checkbox"/> History of fire setting |
| <input type="checkbox"/> Current legal issues / past legal issues | <input type="checkbox"/> History of suicide attempts Date of last attempt: |
| <input type="checkbox"/> Current passive suicidal thoughts | <input type="checkbox"/> History of violence towards self (self-harm) |
| <input type="checkbox"/> Current thoughts of harm to others | <input type="checkbox"/> History of violence toward others or property |
| <input type="checkbox"/> Dissociation | <input type="checkbox"/> Risk of falling, history of recent falls |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Wandering / AWOL risk |

Please provide additional details regarding risks identified above:

Section 6: Post-discharge Care Provider

| | | |
|-----------------|------------------|----------|
| Name: | | |
| Address: | | City: |
| Province/State: | Postal/Zip Code: | Country: |
| Email: | Phone: | Fax: |

Section 6a: Post-discharge Community Care Provider (non-Homewood)

| | | |
|-----------------|------------------|----------|
| Name: | | |
| Address: | | City: |
| Province/State: | Postal/Zip Code: | Country: |
| Email: | Phone: | Fax: |



Section 7: Referrer Information

Section 8: Referral Information

Section 9: Recent Admissions

Section 10: Group Ready

Section 11: Current Medications

Section 12: Significant Medical History

S01:7420



Homewood Health

Homewood Health Centre | The Residence at Homewood | Homewood Ravensview | The Homewood Clinics

Section 13: Addiction

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|--|---|--|----------------------|
| 1. Does the patient currently have any drug or alcohol (substance) problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, skip to section 14</i> | | | |
| 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, describe:</i> | | | |
| 3. Does the patient admit to having a drug or alcohol problem? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| 4. Is the patient currently prescribed the following medications? <i>Note: some programs have specific admission requirements concerning methadone treatment.</i> | | | |
| | 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: | | | |
| 6. Does the client/patient use nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: | | | |

Please note, all inpatient facilities are tobacco free

Section 14 (if applicable):

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| If you are referring to the <u>Eating Disorders Program at Homewood Health Centre</u> additional information will be needed. Forms will be forwarded to the patient. | |
| If you are referring for <u>Traumatic Stress Recovery</u> , please indicate all the types of trauma the client/patient has experienced: | |
| <input type="checkbox"/> Violence <input type="checkbox"/> Accident <input type="checkbox"/> Occupational <input type="checkbox"/> Military <input type="checkbox"/> Childhood <input type="checkbox"/> Other: | |

Thank you for your referral to Homewood Health