

Referral Form for Treatment	Da	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	wood Cli	nic – Vancouver, British Columbia			
☐ Homewood Health Centre – Guelph, Onta			nic – Vancouver, British Columbia			
Ravensview – Victoria, British Columbia			nic – Calgary, Alberta			
☐ The Residence – Guelph, Ontario			nic – Mississauga, Ontario			
Unknown						
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.						
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	llergies:			
Occupation:			ployer Name:			
Health Card #:		Expiry Date:				
Department of National Defense Blue Cross S	Service # (if applicable):					
Veterans Affairs Canada K # (if applicable):						
Workers Compensation Board # (e.g., WSIB,			is here don't see that the see			
Room Accommodation: Semi-Private	Private Note, assigned accomm	noualion i	is based on funder/referring agency approval.			
Section 3: Primary Reason for Referral & F	Return to Work Goal (if applicab	ole)				

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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			
		П	Acute or Chronic Psychosis				Dissociative Disorder		
			(Thoughts disorder/hallucination/delusion) Addiction (drug and/or alcohol)				Eating Disorder		
			ADHD				PTSD, Abuse, Trauma or OSIs (Occupational Stress Injuries (OSI))		
			Anxiety Disorder (Social Phobia or panic disorder)				Major Depression (Unipolar)		
			Autism or Autism Spectrum Disorder			П	OCD (Obsessive Compulsive Disorder)		
			Bipolar Disorder (Hypomania, mania, depression)						
			Chronic Pain				Personality Disorder		
			$Cognitive\ Disorder\ ({\sf Head\ injury,\ memory\ problems})$		Ш		Schizophrenia		
			Dementia				Substance Abuse (drug and/or alcohol)		
			Other (please describe):						
Secti	on 5: Cu	rrent Sa	afety Risks (Check all which apply)		·				
			iicidal thoughts		•				
	Current le	-					tte of last attempt:		
	•		suicidal thoughts History of				-		
		_	of harm to others History of N				property		
	Dissociat		Risk of falli	-	-	nt falls			
	Flashbac		Wandering Donal details regarding risks identified above		IISK				
				-					
Sect	ion 6: Po	st-disc	harge Care Provider						
Nam	ne:								
Addı	ress:						City:		
Province/State: Postal/Zip Code			le:			Country:			
Email: Phone:						Fax:			
· · · · · · · · · ·									
Section 6a: Post-discharge Community Care Provider (non-Homewood)									
Name:									
Address:							City:		
Prov	rince/Stat	e:	Postal/Zip Coo	le:			Country:		
Email: Phone:						Fax:			



Section 7: Referrer Information

Your Name:						
Your Health Care Discipline (e.g. Family Medicine, Social Worker):						
If applicable, Physician/NP Billing #:						
If applicable, Agency (ex. WSIB, DND, V	A):					
Address:		City:				
Province/State:	Postal/Zip Code:		Country:			
Email:	Phone:		Fax:			
If you are from a Health Care Disciplin	e, will you provide this pa	tient care after discharge?	☐ Yes ☐ No			
Section 8: Referral Information						
In order to arrange a timely admission to the most appropriate program, please provide us with clinical information from the past 6 months. Copies of past consults, test results and discharge summaries are very helpful.						
Referral documentation attached:	Medication List	nsent Forms Other:				
Is this patient an urgent referral?	Yes No	Is the patient aware of th	e referral?			
Section 9: Recent Admissions						
1. Has the patient had any psychiatri	c and/or medical hospitali	zations within the last 5 ye	ars? Yes No			
If yes, Where:	When:	Why:				
Please	forward discharge notes of	or consults from hospital sta	ays			
2. Is the patient currently in a hospital	al? 🗌 Yes 🔲 No					
If yes, Where:		Date of admission:				
3. Is their current status involuntary?		∕es □ No				
4. Has the patient tested positive for	C-Difficile MRS	A 🗌 VRE				
Section 10: Group Ready						
	to participate in a group l					
	to reside on an unlocked					
 ☐ Yes ☐ No ☐ Does the patient have a substitute decision maker? ☐ Yes ☐ No Is the patient subject to a Community Treatment Order (CTO)? 						
Tes Tree is the patient subj	cot to a Community Treat	ment order (oro):				
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:			
Sec	Second substance of choice is:				Years of use:	Amount used per day:		
2.	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.	I. Is the patient currently prescribed the following medications? Note: some programs have specific admission requirements concerning methadone treatment.							
			Dosage	:	Prescribed for:	Comments:		
	Methadone	☐ No	Yes	mg/day	addiction treatment chronic pain management			
	Suboxone	□No	Yes	mg/day	☐ addiction treatment☐ chronic pain management			
5.								
6.	Does the clien	ıt/patient	use nicotine?] Yes 🗌 No	Comments:			
Please note, all inpatient facilities are tobacco free								
Section 14 (if applicable):								
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:								
	□ Violence □ Accident □ Occupational □ Military □ Childhood □ Other:							

Thank you for your referral to Homewood Health

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