Homewood Health

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

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.

Reset Form

Secion 1: Preferred Referral Location

Inpatient	Outpatient
☐ Homewood Health Centre – Guelph, Ontario	☐ The Homewood Clinic – Vancouver, British Columbia
☐ Ravensview – Victoria, British Columbia	☐ The Homewood Clinic – Edmonton, Alberta
☐ The Residence – Guelph, Ontario	☐ The Homewood Clinic – Calgary, Alberta
	☐ The Homewood Clinic – Mississauga, Ontario
☐ Unknown	

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: ☐ Semi-Private ☐ Private *Note, assigned accommodation is based on funder/referring agency approval.*		

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

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	
☐	☐	☐	Acute or Chronic Psychosis (Thoughts disorder/hallucination/delusion)
☐	☐	☐	Addiction (drug and/or alcohol)
☐	☐	☐	ADHD
☐	☐	☐	Anxiety Disorder (Social Phobia or panic disorder)
☐	☐	☐	Autism or Autism Spectrum Disorder
☐	☐	☐	Bipolar Disorder (Hypomania, mania, depression)
☐	☐	☐	Chronic Pain
☐	☐	☐	Cognitive Disorder (Head injury, memory problems)
☐	☐	☐	Dementia
☐	☐	☐	Other (please describe):

In the last 6 months	Prior to 6 months ago	Primary Concern	
☐	☐	☐	Dissociative Disorder
☐	☐	☐	Eating Disorder
☐	☐	☐	PTSD, Abuse, Trauma or OSIs (Occupational Stress Injuries (OSI))
☐	☐	☐	Major Depression (Unipolar)
☐	☐	☐	OCD (Obsessive Compulsive Disorder)
☐	☐	☐	Personality Disorder
☐	☐	☐	Schizophrenia
☐	☐	☐	Substance Abuse (drug and/or alcohol)

Section 5: Current Safety Risks (Check all which apply)

☐ Current active suicidal thoughts	☐ History of fire setting
☐ Current legal issues / ☐ past legal issues	☐ History of suicide attempts Date of last attempt:
☐ Current passive suicidal thoughts	☐ History of violence towards self (self-harm)
☐ Current thoughts of harm to others	☐ History of violence toward others or property
☐ Dissociation	☐ Risk of falling, history of recent falls
☐ Flashbacks	☐ 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 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, VA):		
Address:		City:
Province/State:	Postal/Zip Code:	Country:
Email:	Phone:	Fax:
If you are from a Health Care Discipline, will you provide this patient 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 ☐ Consent Forms Other:

Is this patient an urgent referral? ☐ Yes ☐ No | Is the patient aware of the referral? ☐ Yes ☐ No

Section 9: Recent Admissions

1. Has the patient had any psychiatric and/or medical hospitalizations within the last 5 years? ☐ Yes ☐ No
   If yes, Where: When: Why:
   Please forward discharge notes or consults from hospital stays
2. Is the patient currently in a hospital? ☐ Yes ☐ No
   If yes, Where: Date of admission:
3. Is their current status involuntary? (certified inpatient) ☐ Yes ☐ No
4. Has the patient tested positive for: ☐ C-Difficile ☐ MRSA ☐ VRE

Section 10: Group Ready

☐ No	☐ Yes	Is the patient able to participate in a group based program?
☐ No	☐ Yes	Is the patient able to reside on an unlocked unit?
☐ Yes	☐ No	Does the patient have a substitute decision maker?
☐ Yes	☐ No	Is the patient subject to a Community Treatment Order (CTO)?

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	☐ No	☐ Yes	mg/day	☐ addiction treatment ☐ chronic pain management	
Suboxone	☐ No	☐ Yes	mg/day	☐ addiction treatment ☐ 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

All forms and copies of past records and reports should be sent as soon as possible to:
Fax: 1.855.895.0666 or Email: treatment@homewoodhealth.com

We will contact you once a decision has been made regarding your patient's admission. If you have any questions, please contact our Intake Consultants at 1.866.221.0237. We are available Monday through Friday from 9:00 AM to 10:00 PM EST, and Sunday from 1:00 PM to 9:00 PM EST (excluding statutory holidays) .