GROW
At school. At work. In your community.

Referral Form

ISLAND COMMUNITY MENTAL HEALTH

Date: _____

Client name: _____ DOB: _____
(Surname) (First Name) (Month/Day/Year)

Preferred Pronoun: _____

Address: _____ Postal Code: _____

Telephone: _____ Email: _____

In case of emergency Please notify:_____ Phone: _____

PROFESSIONAL SUPPORT

Psychiatrist:_____ phone: _____

Physician: _____ phone: _____

Case Manager:_____ phone: _____

Other: (please specify):_____ phone: _____

MEDICAL INFORMATION

Primary Diagnosis: _____

Secondary Diagnoses: _____

Any adverse side effects from prescribed medications?

_____

_____

Distress signals:

_____

_____

HISTORY AND BACKGROUND INFORMATION

Psychiatric hospitalizations (date, duration, reason): _____

_____

_____

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Past suicide attempts: ❑Yes ❑No If yes, please describe: _____

_____

Current active or passive suicidal ideation: ❑Yes ❑No If yes, attach most recent risk assessment and/or safety plan:

_____

_____

Alcohol/substance use past and present (and stage of change):

_____

_____

Is there a history of violence or aggression ❑Yes ❑No If yes, please describe:

Behavioural issues:

_____

_____

ADLs/IADLs:

_____

_____

Concurrent Programming:

_____

_____

SPECIFIC GOALS FOR PARTICIPATION IN A PSYCHOSOCIAL REHABILITATION PROGRAM:

_____

_____

REFERRED BY: _____ Telephone #: _____

Signature and title of Referring Agent: _____

Please return or fax attention: GROW | 125 Skinner Street | (Fax) 250-389-1263