Networks

ISLAND COMMUNITY MENTAL HEALTH

Referral Form

Date of Referral: ______________________________

CLIENT INFO: ____ Preferred Pronoun: _________________
Last Name First Name

DOB: ___________________ Phone: ___________________________ Email:__________________________
MM/DD/YY

Address: ____
Street City Postal Code

Emergency Contact: ____ Phone: ______________________
Name Relationship

PROFESSIONAL SUPPORT

Referring Clinician (if applicable): ____
Name Role Clinic/Program Name

Phone: _________________________ Email: _________________________________

☐ GP or ☐ Walk-in Doctor: ____ Phone: _________________
Name Clinic Name

Additional Referring Clinician:

☐GP ☐Psychiatrist ☐Case Manager ☐Social Worker ☐OT ☐Support Worker ☐Self-referral

____ Phone: ___________________
Name Role Clinic/Program Name

MEDICAL & SAFETY INFORMATION

Presenting Mental Health Challenge(s): ____

Relevant Physical/Cognitive Challenge(s): ____

Most Recent Psychiatric Hospitalization: ____
Date Range Reason

Current risk of suicide/self-harm?	☐ Yes ☐ No	Details:
Current risk of harm to others?	☐ Yes ☐ No	Details:
Substance Use (past or present)?	☐ Yes ☐ No	Details:

EDUCATION AND EMPLOYMENT

1. What is the person saying about Education / Employment? Why do they want Education / Employment now?

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Please return or fax, attn: *Networks* | 125 Skinner Street Victoria BC V9A 6X4 | Fax: 250-389-1263

2. Is this person interested in gaining more education to advance their career goals?

3. What are some of the person's strengths? (Experience, training, personality, supports, etc.)

4. Please include some information about the person's illness (diagnosis, symptoms, etc.). How might the person's illness (and/or substance use) affect a job or return to school? Are there any additional barriers?

5. What type of Education / Employment do you think would be a good match? Why?