PATIENT LABEL

# CASA House Referral

Date of Referral (dd/mm/yyyy): _____

Forms completed electronically should be printed and faxed to CASA. Please fax referral to 780-416-4588

## PATIENT INFORMATION:

**Legal Name**
First Name: Last Name:

**Preferred Name** (If applicable)

**Date of Birth** (dd/mm/yyyy):

**Gender:**
☐ Female ☐ Trans Woman ☐ Two-Spirit ☐ Gender fluid ☐ Non-binary
☐ Male ☐ Trans Man ☐ Genderqueer ☐ Androgynous ☐ Other: _____

**Health Card Information:**
Health Card #: Version Code: Expiration Date (dd/mm/yyy)

**Patient Address:**

Address: _____

City: _____ Province: _____ Postal Code: _____ Unit #: _____

**Is there a need for an interpreter?** ☐ Yes ☐ No If yes, please specify which language:_____

**Are there any accessibility concerns?** ☐ Yes ☐ No If yes, please Specify:_____

## CUSTODY STATUS: Please attach custody or guardianship documents with this referral

☐ Lives with both parents (Please fill out contact information for both guardians)
☐ Joint Custody (Please fill out contact information for both Guardians
☐ Sole Custody (Please fill out contact information for the sole guardian)
☐ Temporary Guardianship Order
☐ Permanent Guardianship Order
☐ Other – please specify:_____

## PARENT/GUARDIAN CONTACT INFORMATION:

| | |
|---|---|
| Name: | Name: |
| Relationship: | Relationship: |
| Address: | Address: |
| Phone: | Phone: |
| Email: | Email: |

The information collected on this intake form is used to access the services of CASA Mental Health and is collected pursuant to section 22(2)(b) of the Health Information Act (HIA) in accordance with sections 20(b) and 21(1)(a) of the HIA. The Health Information Act and/or Personal Information Protection Act Protects the privacy of this information.

## REFERRING PROVIDER INFORMATION:

**Name**
First Name: Last Name:

**Billing Number:**

**Please select one of the following:**
☐ Therapist
☐ Psychologist
☐ Psychiatrist
☐ Family Physician

**Referring Provider Address:**

Address: _____

City: _____ Province: _____ Postal Code: _____ Unit #: _____

| **Telephone:** | **Fax:** | **Email:** |
|---|---|---|

**Does your patient currently have a psychiatrist?** ☐ Yes ☐ No ☐ Unknown
If yes, please indicate the name of the psychiatrist: _____
If yes, will this psychiatrist continue to provide care after discharge? ☐ Yes ☐ No

**Does your patient currently have a mental health therapist?** ☐ Yes ☐ No ☐ Unknown
If yes, please indicate the name of the therapist: _____
If yes, will this therapist continue to provide care after discharge? ☐ Yes ☐ No

**If the patient has a psychiatrist, it is preferred the referral comes from them. Alternatively, please attach consultation notes**

## 1. REASON FOR REFERRAL:

**Please indicate the primary reason for referral** (specify current symptoms, presenting problems and history)

**SUMMARY OF ATTACHED DOCUMENTATION:**

- The referral form.
- A mental health assessment.
- Psychological assessments and/or school reports.
- Discharge summary from previous mental health programs or hospital admissions.
- Any relevant supporting documentation.

**If any of the necessary documents are not submitted, the referral will be considered incomplete**

## 2. PATIENT ENGAGEMENT:

☐ Is the patient aware of the referral and interested in attending CASA House?
☐ Are the guardians in agreement and understanding of the program commitments?

## 3. SUBSTANCE USE (In space below, indicate current substances, amount, frequency, etc.

## 4. RISKS AND SAFETY CONCERNS

This information is used to optimally plan for the patient's first appointment, and to ensure their safety and the safety of our staff.

| Risk Issue: | Yes: | No: | If yes, when (dd/mm/yyyy) | Details: |
|---|---|---|---|---|
| Suicide Attempt/Ideation | ☐ | ☐ | | |
| Deliberate Self-harm | ☐ | ☐ | | |
| Violent Behavior/Aggression towards others | ☐ | ☐ | | |
| Legal Involvement | ☐ | ☐ | | |
| Fire Setting | ☐ | ☐ | | |
| AWOL | ☐ | ☐ | | |

**If any of the above risks and safety concerns are selected, you are REQUIRED to provide additional details**

## 5. MEDICATION: (Please attach full medication history to the referral)

| Medication | Current | Dose | Frequency | Response & Adverse Effects |
|---|---|---|---|---|
| | ☐ Yes ☐ No | | | |
| | ☐ Yes ☐ No | | | |
| | ☐ Yes ☐ No | | | |
| | ☐ Yes ☐ No | | | |
| | ☐ Yes ☐ No | | | |
| | ☐ Yes ☐ No | | | |

## 6. SCHOOL/ACADEMICS:

| | |
|---|---|
| Working at grade level | ☐ Yes ☐ No |
| Learning disability | ☐ Yes ☐ No |
| Requires academic or behavior support in a school setting | ☐ Yes ☐ No |
| Psychoeducational testing or school report cards attached | ☐ Yes ☐ No |

## 7. AGENCIES, HOSPITALS, OR THERAPIE INVOLVED WITHIN THE PAST 2 YEARS:

| Organization/Name of provider: | Describe involvement: |
|---|---|
| | |
| | |
| | |

## 8. RELEVANT MEDICAL/DEVELOPMENTAL HISTORY (e.g. disabilities, intellectual delay, autism, allergies, endocrine, neurological, respiratory, cardiac, prenatal exposure to drugs or alcohol, metabolic or other issues)

Completed by:

Print name and credentials

Signature