PATIENT LABEL

CASA House Referral

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

External referrals must be made by a health professional, such as a physician or therapist, and faxed to Alberta Health Services at 780-408-8776

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