Patient Label

# CASA Tertiary Programs Referral

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

**Program Requested:**

CASA House (ages 12-17)
https://casamentalhealth.org/getting-help-2/casa-house/
Adolescent Day Program (ages 13-17)
https://casamentalhealth.org/getting-help-2/adolescent-day-program/
Children's Day Program (ages 8-12)
https://casamentalhealth.org/getting-help-2/childrens-day-program/

**Patient Information:**

| | | | |
|---|---|---|---|
| Legal First Name: | | Legal Last Name: | |
| Preferred Name: | | Date of Birth: (dd-mmm-yyyy) | |
| Health Care Number: | Version Code: (if applicable) | Expiration Date: (if applicable) | |
| Gender: ☐ Male ☐ Female ☐ Transgender ☐ Two Spirit ☐ Other | | | |
| Address: | | City: | Postal Code: |
| Is there a need for an interpreter? ☐ Yes ☐ No<br>If yes, specify which language: _____ | | Are there any accessibility concerns? ☐ Yes ☐ No<br>If yes, please specify: _____ | |

**Caregiver / Guardian Information:** Fill out contact information for both parents/guardians with joint custody, or just one for sole custody. Please include custody or guardianship documents with this referral.

| | | | |
|---|---|---|---|
| Name: | | Name: | |
| Relationship: | | Relationship: | |
| Address: (if different from above) | | Address: (if different from above) | |
| City: | Postal Code: | City: | Postal Code: |
| Phone: | | Phone: | |
| Email: | | Email: | |
| Custody: ☐ Lives with both parents<br>☐ Joint ☐ Sole ☐ Temporary Guardianship<br>☐ Permanent Guardianship ☐ Other: (specify) _____ | | Custody: ☐ Lives with both parents<br>☐ Joint ☐ Sole ☐ Temporary Guardianship<br>☐ Permanent Guardianship ☐ Other: (specify) _____ | |

**Referring Provider Information:**

| | | | |
|---|---|---|---|
| Mental Health Professional Name: | | PRAC ID: (required) | ☐ Therapist ☐ Psychologist ☐ Psychiatrist ☐ Family Physician |
| Address: | | Town/City: | Postal Code: |
| City: | | Postal Code: | |
| Phone: | Fax: | Email: | |

Does your patient currently have a psychiatrist? ☐ Yes ☐ No ☐ Unknown

If yes, name of psychiatrist: _____ 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, name of therapist: _____ 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.

**Primary Reason for the Referral:** (specify current symptoms, presenting problems, and history, functional impact in the home, school, or community setting).

**Summary of Attached Documentation:** If any of the necessary documents are **NOT** submitted, the referral will be considered **INCOMPLETE**.

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.

**Patient and Family Engagement:**

Are the patient and their caregiver aware of the referral and interested in attending CASA House, Adolescent Day Program, or Children's Day Program?
Have the guardians read the program information outlining the program commitments?

**Substance Use:** (indicate current substances, amount, frequency, etc.)

**Risk 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-mmm-yyyy) | Details |
|---|---|---|---|---|
| Suicide attempt/ideation | ☐ | ☐ | | |
| Deliberate self-harm | ☐ | ☐ | | |
| Violent behavior/aggression to others | ☐ | ☐ | | |
| Legal involvement | ☐ | ☐ | | |
| Fire-setting | ☐ | ☐ | | |
| AWOL | ☐ | ☐ | | |

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

**School/Academics:**

| | | | |
|---|---|---|---|
| Working at grade level? | ☐ Yes | ☐ No | |
| Learning disability? | ☐ Yes | ☐ No | ☐ Suspected |
| Requires academic or behavior support in a school setting? | ☐ Yes | ☐ No | |
| Psychoeducational testing or school report cards attached? | ☐ Yes | ☐ No | |
| Does the guardian consent to EPSB Hospital School Campuses accessing the student's school record? | ☐ Yes | ☐ No | |

**Agencies, Hospitals, or Therapy Involvement:** (within the past 2 years). Services include speech-language pathology, audiology, vision, occupational therapy/physiotherapy, mental health, psycho-educational, etc.

| Organization/Name of Provider | Describe Involvement |
|---|---|
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**Family Support for Children with Disabilities (FSCD):**

Applied: ☐ Yes ☐ No If yes, approved: ☐ Yes ☐ No

Details of Support Plan:

**Relevant Medical/Developmental History:** (i.e., disabilities, intellectual delay, autism, allergies, endocrine, neurological, respiratory, cardiac, prenatal exposure to drugs or alcohol, metabolic or other issues).

| |
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| |

Completed by:

| Name and Credentials: (print) | Date: |
|---|---|
| Signature: | |

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.