# Northeastern Recovery Centre

REFERRAL FORM

**Program:** ☐ **Bedded Treatment** ☐ **Bedded Withdrawal Management**

**Referral Date:** ______________________ **Referring Source:** ______________________

**Referring Agency:** ______________________ **Contact Person:** ______________________

**Phone:** ______________________

**Assessments Included:** ☐ ADAT ☐ GAINS Q3 ☐ GAIN-SS ☐ Other:______________________

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## Client Information

**First Name:**______________________ **Middle Name:**______________________

**Last Name:**______________________ **Last Name at Birth:** ______________________

**Preferred Name:**______________________ **D.O.B:** ______________________ **Age:** ________

**Gender:** ☐ Male ☐ Female ☐ Other ☐ Declined ☐ Unknown

**Preferred Language:** ______________________ **Francophone:** ☐ Y ☐ N

**Health Card #:** ______________________ **Indigenous and/or Metis:** ☐ Y ☐ N

**Street Address:** ______________________

**Town:** ______________________ **Province:** __________ **Postal Code:** __________

**Home Phone:** ______________________ OK to call ☐ Y ☐ N OK to Leave Message ☐ Y ☐ N

**Cell Phone:** ______________________ OK to call ☐ Y ☐ N OK to Leave Message ☐ Y ☐ N

**Alternate Phone:** ______________________ OK to call ☐ Y ☐ N OK to Leave Message ☐ Y ☐ N

**Current Location** (if different from above): ______________________

**Email:** ______________________

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## Emergency Contact

**Name:** ______________________ **Relationship:** ______________________

**Address:** ______________________

**Phone:** ______________________ OK to call ☐ Y ☐ N OK to Leave Message ☐ Y ☐ N

## Substance Use

**Presenting Problem Substances (Drugs of Choice) / Frequency of Use**:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Last Date Substance Used**: ______________________ **Substance(s)**:________________________

**Previous Treatment**: ☐ Y ☐ N **If yes, Where and When**: _____________________________________

______________________________________________________________________________

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## Risk Assessment

**History of Withdrawal Symptoms or Complications**: _________________________________

**Please mark any of the following risks that may apply:**

☐ Self-harm or Suicidal Ideation
☐ Risk of Harm to Others
☐ Severe Mental Health Crisis
☐ Homelessness or Housing Instability
☐ Aggression or Violent Behaviour
☐ History of Overdose
☐ Medical Complications (e.g., withdrawal risks)
☐ Other: ____________________________

**Exclusionary Criteria:**
If any of the following criteria are met, please refer to the appropriate service provider (e.g., emergency department, addiction clinic):

☐ New cough, fever, vomiting, diarrhea (not associated with withdrawal symptoms)
☐ Acute serious injuries requiring medical attention (e.g., broken bones, head injuries)
☐ Acute psychosis or mania
☐ Inadequately controlled chronic psychiatric disorders
☐ Active suicidal or homicidal ideation with plan or intent
☐ History of hallucinations or seizures when stopping substance use
☐ History of delirium tremens (DTs)
☐ Current agitation or aggression
☐ Chronic medical conditions requiring significant medical monitoring (e.g., severe CHF)
☐ 17 years of age or under
☐ Uncontrolled hypertension/tachycardia

*Admission may be appropriate after medical assessment for the following:

☐ Minor acute injuries (e.g., open sores, wounds, skin infections)
☐ Have stopped medication for chronic illnesses within the last 60 days
☐ Pregnant or thinks they may be pregnant
☐ Missing medications for chronic or acute illnesses (e.g., insulin, blood pressure medication)
☐ Concurrent benzodiazepine and alcohol withdrawal
☐ History of seizures --If yes: On treatment? ☐ Y ☐ N Date of last seizure:________________

## Medical/Health

**Health Care Provider:** ________________________________ **Phone:** ____________________________

**Address:** ___________________________________________ **Fax:** ____________________________

**Current Pharmacy:** ________________________________ **Phone:** ____________________________

**Address:** ___________________________________________ **Fax:** ____________________________

***Please include updated Medication Profile from Pharmacy with this referral.**

**Disability:** ☐ Visual ☐ Hearing ☐ Mobility **Pregnant:** ☐ Y ☐ N ☐ Unknown ☐ N/A

**Health Conditions/Problems/Allergies:** _________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**Ever had a Transmittable Illness/Disease:** ☐ Y ☐ N ☐ Unknown

If yes, what: ______________________________________________________________________________

**Diagnosed with a Mental Health problem by a qualified Mental Health Professional:**

Within the last 12 Months: ☐ Y ☐ N ☐ Unknown Within Lifetime: ☐ Y ☐ N ☐ Unknown

**Most Recent Diagnosis:** _____________________________________________________________________

**Hospitalized for a Mental Health Problem:**

Within the last 12 Months: ☐ Y ☐ N ☐ Unknown Within Lifetime: ☐ Y ☐ N ☐ Unknown

**Received Treatment for a Mental Health, Emotional, Behavioural or Psychological problem from a community Mental Health Program or Professional:**

Currently: ☐ Y ☐ N ☐ Unknown Within the Last 12 Months: ☐ Y ☐ N ☐ Unknown

Within Lifetime: ☐ Y ☐ N ☐ Unknown

Name of Service Provider: ________________________________ Phone: ___________________________

**Prescribed Medication for a Mental Health Problem?**

Currently: ☐ Y ☐ N ☐ Unknown Within the Last 12 Months: ☐ Y ☐ N ☐ Unknown

Within Lifetime: ☐ Y ☐ N ☐ Unknown

Name and dosage of Medication: ____________________________________________________________

_____________________________________________________________________________________________

**Additional Information**

____________________________________________________________________________

***Please attach any other relevant documents and assessments to this referral and send to:**

**Canadian Mental Health Association – Cochrane Timiskaming**
**Attn: Northeastern Recovery Centre Program**
**31 Station Rd North PO Box 552**
**Kirkland Lake, ON P2N 2C7**
**Fax: 705-567-5211**
**NRCKirklandLake@cmhact.ca**

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I, ___________________________________, consent to this referral.

☐ I provide consent to CMHA-CT to contact the source of this referral.

☐ I provide consent to CMHA-CT to contact my pharmacy and request a medication profile.

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above. • I understand that there are some circumstances in which this information may be re-disclosed to other parties and no longer protected by federal privacy laws. • I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission. • I have read all pages of this form and agree to the disclosures above from the types of sources listed.

**Signed this______________Day of___________________________________, 20 ______________**

| ___________________________________ | ___________________________________ |
| --- | --- |
| **Printed Name of Applicant** | **Signature of Applicant** |