# PROGRAM REFERRAL FORM

1019 - 7th Avenue S.W. Calgary, AB T2P 1A8
Phone: 403.266.8711 Fax: 403.266.2478

Referral Date: ____________________

*Please indicate program choice and rank in order of preference 1st, 2nd, 3rd*

______ **Art Program**
______ **Best of Me**
______ **Connections – AM**
______ **Connections – PM**
______ **Creative Arts**
______ **Decluttering**
______ **Initiatives**

**Support Groups:**
______ **Mental Health**
______ **Reach for Recovery**

______ **Support & Recreation Services**
______ **Volunteer Program**

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Name: ________________________________________________
First Surname Middle

Address: ______________________________________________

City: ____________ Postal Code: ____________ Phone Number: ____________

Alberta Health Care #: ______ ______ ______ ______ ______ - ______ ______ ______ ______

Birthdate: ____________________ Gender: ____________________
(YYYY/MM/DD)

Income: ______AISH ______Old Age/CPP ______No Funds
______Alberta Works ______Own Funds ______Other

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Emergency Contact: ____________________ Relationship: ____________

Phone: ____________________ Address: ____________________

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Referral Source: ______________________________________________

Referring Worker: ______________________________________________
Name Phone Number

Reason for Referral:

______________________________________________

______________________________________________

______________________________________________

**MENTAL HEALTH DIAGNOSIS:**

___Depression ___Personality Disorder ___Obsessive Compulsive Disorder
___Anxiety ___Bipolar Disorder ___Substance Related Disorder
___Schizophrenia ___Intellectual Disability ___Other (specify)_______________________________

**MENTAL HEALTH/MEDICAL:**

Physician: ___________________________________ Clinic: _________________ Phone: _________________
Current Psychiatrist:_________________________ Hospital: ______________ Phone: _________________
Past Psychiatrist: ____________________________ Hospital: ______________ Phone: _________________
Current Case Manager:______________________ Agency: _______________ Phone: _________________

Mental Health Treatment Summary (past hospital admissions, mental health follow-up, counselling). List most recent treatment first.

| DATE | LOCATION | PSYCHIATRIST/WORKER | REASON |
|---|---|---|---|
| | | | |
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| | | | |
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**MENTAL HEALTH FOLLOW UP:**

_____Hospital _____Psychiatrist _____MH Clinics
_____Community Agency _____Physician _____No follow-up
_____Unknown _____Other (specify) ________________________________________________

**MEDICATIONS:** **DOSAGE:**

_____________________________________________________ ___________________________________________
_____________________________________________________ ___________________________________________
_____________________________________________________ ___________________________________________
_____________________________________________________ ___________________________________________
_____________________________________________________ ___________________________________________

Other medical conditions (Epilepsy, Diabetes, heart, allergies, etc.)

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Community Service Involvement (day hospital, special housing, alcohol/drug treatment, justice system, counselling, other)

| PROGRAM NAME | CURRENT | PAST | CONTACT PERSON |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |

**IDENTIFIED NEEDS**:
*Please check the area(s) in which the applicant requires support/services:*

**Primary** *(choose one)*

_____**Mental Health**
_____**Addictions**

Additional

_____Abuse
_____Addictions
_____Behavioural
_____Financial
_____Healthy Lifestyle
_____Housing
_____Interpersonal
_____Learning
_____Legal
_____Leisure Activity
_____Medical/Health
_____Mental Health
_____Skill Dev./Educational
_____Volunteer work
_____Other
__________________________

Comments on identified needs:

______________________________________________

______________________________________________

______________________________________________

Applicant Signature: ___________________________________________

Referring Worker:

This will confirm that I have a Release of Information to provide information to Elements Calgary Mental Health Centre.

Signed _________________________________________ Date _________________________________