# Referral form

Name of client: _____ DOB: ____/____/____
Yr Mo D

Address: _____
No. Street City Postal code

Phone number: _____ Tel (other): _____

Language: French:_____ English:_____ Other:_____

Referred by: _____ Tel: _____

Profession/Relationship: _____ Email:_____

## Personal information 

Civil status (☒) : Married _____ Single _____ Divorced _____ Widow(er)_____

Number of children (☒): 0 _____ 1 _____ 2 _____ 3 _____ 4 _____

Living accommodation (☒): Apartment _____ Family _____ Foster home _____

Room _____ Supervised apt. _____ Other: _____

Source of revenue (☒): Social welfare _____ Employment _____ UIC _____

Pension:_____ Other: _____

## Medical history 

Name of psychiatrist/G.P.: _____ Phone No: _____

Present medication: _____

_____

Diagnosis and/or resume of psychiatric history: _____

_____

_____

Reason for referral: _____

_____

_____

Clients objectives:_____

_____

_____

Other Resources:_____

_____

_____

Name and phone no of friend/relative:

_____

Comments or significant elements concerning referred client:_____

_____

_____

_____

The client consents to meeting with a community worker: Yes ____ No _____

Signature of referring person: _____ Date: _____

**Release of information**

I authorize Perspective Communautaire en Santé Mentale to exchange personal information with my intervening parties for a 90 day period.

Signature of client: _____ Date : _____