Referral Form for Treatment

RESET FORM

Date of Referral: _____

Section 1: Preferred Referral Location

Homewood Health Centre – Guelph, Ontario ☐

The Residence at Homewood – Guelph, Ontario ☐

Homewood Ravensview – Victoria, British Columbia ☐

Therapy@Home - Virtual Outpatient Services ☐

Section 2A: Referrer Information

Please note, all inpatient facilities are smoke-free and tobacco-free.

Your Name: _____ Phone Number: _____ Ext: _____

Your Health Care Discipline (e.g. Family Medicine, Social Worker): _____

Physician Billing #/NP Billing # (if applicable): _____

Agency (if applicable) e.g. WSIB, DND, VAC: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Country: _____

Fax Number: _____ Email: _____

If you are from a Health Care Discipline, will you provide post discharge care: Yes ☐ No ☐

Section 2B: Complete only if this referral is from RCMP Health Service or from Veteran's Affairs Canada

Please note, all inpatient facilities are smoke-free and tobacco-free.

Is the Member you're referring currently receiving services from an Operational Stress Injury (OSI) Clinic? Yes ☐ No ☐

If yes, please complete the following information: _____

OSI Provider Name & Designation: _____

Provider Contact information Phone: _____ Email: _____

How many years has the Member been receiving services from the OSI: _____

If you are from a Health Care Discipline, will you provide post discharge care: Yes ☐ No ☐

Section 3: Client/Patient Demographic Information

Client/Patient Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Country: _____

Phone Number: _____ Alternate Phone Number: _____

Email Address: _____ Health Card #: _____

Department of National Defence Blue Cross Service # (if applicable): _____

Veterans Affairs Canada K# (if applicable): _____

Workers Compensation Board # (e.g. WSIB, WCB, Worksafe BC): _____

Thank you for your referral to Homewood Health. All forms and copies of past records and reports should be emailed as soon as possible to:
Email: ravensviewreferral@homewoodhealth.com | Fax: 1-855-895-0666

We will contact you once a decision has been made regarding admission. If you have any questions, please contact our Intake Team at 1-866-203-1793 or 250-999-2768. We are typically available (excluding holidays) Monday to Friday from 5:00 AM to 5:00 PM PST

Section 4: Patient Referral information

Reason for referral: Addiction/SUD ☐ Mental Health ☐ Concurrent Mental Health + SUD ☐ Gambling ☐
Eating Disorder ☐ Trauma ☐ Concurrent Trauma + SUD ☐

Substance(s) of choice (if applicable): _____

Methadone: No ☐ Yes ☐ Dosage: _____ mg/day Reason: _____

Suboxone: No ☐ Yes ☐ Dosage: _____ mg/day Reason: _____

Has patient ever experienced severe withdrawal symptoms (DTs, psychosis, seizure, etc): No ☐ Yes ☐

_____

_____

To assist in a timely admission, if applicable, please provide the following information with your referral: Consent Form(s) ☐ Medication List ☐

Relevant Medical History: ☐ _____

Previous Mental Health Hospitalizations/Inpatient Admissions: ☐

Location:	Date:	Reason:

If patient is being referred for Trauma Treatment, please indicate all types of trauma experienced:

Violence/Sexual ☐ Accident ☐ Occupational ☐ Military ☐ Childhood ☐

Section 5: Conditions/Diagnoses and Risks

Diagnosis	Current Concern	Historical Concern	Query
Acute or Chronic Psychosis	☐	☐	☐
ADHD	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐
Bipolar Disorder	☐	☐	☐
Borderline Personality Disorder	☐	☐	☐
Cognitive Disorder (other than Dementia)	☐	☐	☐

If yes, please describe: _____

_____

Diagnosis	Current Concern	Historical Concern	Query
Dementia	☐	☐	☐
Dissociative Disorder	☐	☐	☐
Eating Disorder*	☐	☐	☐
PTSD - Trauma or OSI	☐	☐	☐
Major Depression	☐	☐	☐
Obsessive Compulsive Disorder	☐	☐	☐
Schizophrenia	☐	☐	☐
Substance Abuse (drug or alcohol)	☐	☐	☐

*referrals for Eating Disorder will be required to complete a separate package, and submit recent lab work and ECG, prior to consideration.

Current Safety Risks:

☐ Previous Suicidal Attempt. If applicable, date of last attempt: _____ Method: _____

☐ Active Suicidal Thoughts. If applicable, explain: _____

☐ Self Harm. If applicable, explain: _____

☐ Fire setting Behaviours. If applicable, when: _____

☐ Violence towards others ☐ Wandering/AWOL risk ☐ History/risk of falling

☐ Patient is subject to a CTO ☐ Patient has a Substitute Decision Maker (SDM)

☐ Patient currently in hospital involuntary. Explain: _____

☐ Other: _____

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Homewood RAVENSVIEW