Canadian Mental Health Association
Calgary Region

Street Outreach Stabilization Program
Referral Form

Date of Referral: _____
mm/dd/yyyy

It is recommended that the referral source and applicant complete this form together.

Applicant Information:

Surname	First Name	Middle Name
Address	City, Province	Postal Code
Date of Birth Day Month Year	Phone Number ( )	May we leave a message? ☐ Yes ☐ No
Personal Health Number	Gender	Marital Status
Source of Income (i.e. AISH, CPP)	Annual Income	Cultural Background
Primary Language		

Reason for Referral_____

_____

_____

Referral Source:

Referring Agency:	Contact Name:
Frequency of contact (past 12 months):	Relationship to applicant:
Address:	Phone: ( ) Fax: ( )

In accordance with the Health Information Act, the Mental Health Act, the Freedom of Information and Protection of Privacy Act of Alberta, and the Personal Information and Protection Act, applicants will be informed that all personal information collected will be used for the purpose of assessment, program evaluation and safety. Applicants who wish to appeal a decision related to services can direct their inquiries to the Director of Outreach Services.

Revised February 2012

Family Support/Emergency Contact:
Name:_____

Relationship to applicant: _____

Phone No: (_____) _____

Address:_____

_____

Professional Supports:

Psychiatrist	Phone ( )	Address	Will remain involved in care □ Yes □ No
Physician	Phone ( )	Address	□ Yes □ No
Clinical Support/Case Manager	Phone ( )	Address	□ Yes □ No
Financial Support Worker	Phone ( )	Address	□ Yes □ No
Other (Guardian, Trustee, Outreach)	Phone ( )	Address	□ Yes □ No
Other	Phone ( )	Address	□ Yes □ No

Psychiatric and Physical Health Concerns:

Diagnoses:
Psychiatric:_____

_____

Physical Health:_____

_____

Number of hospitalizations in the past two years due to mental health: _____

Date of most recent mental health hospitalization and reason for admission: _____

_____

Medication:

Psychiatric:	Other:

In accordance with the Health Information Act, the Mental Health Act, the Freedom of Information and Protection of Privacy Act of Alberta, and the Personal Information and Protection Act, applicants will be informed that all personal information collected will be used for the purpose of assessment, program evaluation and safety. Applicants who wish to appeal a decision related to services can direct their inquiries to the Director of Outreach Services.

Revised February 2012

Please do not write in this margin

Comments: _____

_____

Known Allergies (medications, food, environmental): _____

_____

Substance Abuse/Addictions:

	□ Current □ Historical
	□ Current □ Historical
	□ Current □ Historical
Tobacco Use: □ Yes □ No Amount:	□ Current □ Historical

Addiction Treatment History: _____

_____

Please check any of the following that are relevant to applicant:

Risk factors:

□ Suicidal ideation
□ Suicidal attempts
□ Self harm
□ Aggression/violence
□ Anger management
□ Allergies (life threatening)
□ Other _____

Special considerations:

□ Communication concerns
□ Cultural considerations
□ Legal Involvement
□ Mobility issues

If yes to any of the above please provide details: _____

_____

_____

Identified Needs: Please check the area(s) in which the applicant requires support/services to maximize or maintain independence

□ Home management
□ Financial/Income
□ Social Supports
□ Cooking and Nutrition
□ Educational
□ Personal Hygiene
□ Coping Skills
□ Daily Routines and Activities
□ Mental Health Management
□ Physical Health Management
□ Leisure recreation
□ Vocational/Employment/Volunteering
□ Personal Safety
□ Transportation Training and Access
□ Housing
□ Other_____

Revised February 2012

Please add any additional comments or suggestions that will facilitate service planning for the applicant:_____

_____

_____

Current Housing Situation:

- ☐ Homeless - Couch surfing
- ☐ Homeless - Shelter
- ☐ Homeless - Street
- ☐ Hospital
- ☐ Other_____
- ☐ Unknown

Housing History (Past 5 Years):_____

_____

_____

Please attach a copy of the following prior to transmittal (if available):

- ☐ Psychiatric Assessment
- ☐ Current Medication Administration Record
- ☐ Current Functional Assessment
- ☐ Any other information you feel is relevant.

☐ **I have attached a valid Release of Information**

I verify that the above information is complete and accurate to the best of my knowledge:

Signature of Applicant:_____ Date:_____ mm/dd/yyyy

Signature of Referral Source:_____ Date:_____ mm/dd/yyyy

Please return completed application to:

SOS Program Manager
Canadian Mental Health Association – Calgary Region
Suite 400, 105 12th Avenue SE
Calgary, AB T2G 1A1

Phone: (403) 297-1714
Fax: (403) 270-3066

In accordance with the Health Information Act, the Mental Health Act, the Freedom of Information and Protection of Privacy Act of Alberta, and the Personal Information and Protection Act, applicants will be informed that all personal information collected will be used for the purpose of assessment, program evaluation and safety. Applicants who wish to appeal a decision related to services can direct their inquiries to the Director of Outreach Services.

Revised February 2012

Please do not write in this margin