Dilico
Anishinabek Family Care

# REFERRAL FOR SERVICES (ADULT)
## District Mental Health & Addictions Services

**Purpose:** For applicable workers (i.e. District Staff, Fort William First Nation Staff, Probation Services, Internal, Self, etc.) to access Adult District Mental Health & Addictions Services.
**Instructions:** 1) Fill all dates accordingly (mm/dd/yy) 2) Provide all required information 3) Sign and return completed form to relevant Staff/District Office

☐ Addictions Services ☐ Adult Case Management

| | |
|---|---|
| Date of Referral: | Request Processed via: ☐ Person ☐ Fax ☐ Phone ☐ Letter |
| Referral Taken by: | Position: |

| | | |
|---|---|---|
| Source of Referral: | Relationship to Client: | How to Contact: |

| | | |
|---|---|---|
| **CLIENT:** | | **File No.:** |
| DOB: | Age: | Gender: |
| Band Name & No.: | Health Card No.: | |
| Address: | | |
| Postal Code: | Telephone No.: | |
| Where is Client now: | | |
| Is Client Aware of Referral? ☐ Yes ☐ No (check one box) | | |

**Reason(s) for Referral:** (Be descriptive; include charges, convictions, crisis, etc.) Add extra sheets, as required

**Any other Mental Health services involved? Please list:**

**Suicide:** Has the client ever had thoughts of suicide ☐ Yes ☐ No (check one box)
Any previous attempts? If so please provide details (when, how)
Explain:

☐ **Addictions**

☐ **Concurrent disorder (mental health issues & substance abuse**

☐ **Dual Diagnosis (developmental delay & mental health issue)**

☐ **Forensic (involvement with the legal system)**

☐ **Mental Health issue only (no substance use)**

☐ **Crisis (Explain):**

**Any Substance Use:** (prescriptions, herbal, traditional, OTC's, illegal) ☐ Yes ☐ No (check one box)
Explain:

**MANAGER TO COMPLETE THIS SECTION:**

Referral Accepted: ☐ Yes (Date:_____)

☐ No (Explain:_____)

Plan for Client:_____

_____

_____

_____

_____

_____ _____

Manager's Signature Date