Langley Community Services Society — Serving Our Community Since 1971

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INTENSIVE CASE MANAGEMENT: PARTICIPANT REFERRAL FORM

PLEASE FAX ALL REFERRALS TO 604-514-1419

Please make sure to enter as much information as you can.

REFERRAL FORM : Program or person referring those to be receiving requested services

Person completing Referral: _____ **Referral Date:** _____
(Please print) (DD/MM/YYYY)

Referral Source: _____ **Role:** _____
(i.e.: Self, program, site)

Phone Number: _____ **Address:** _____

PARTICIPANT INFORMATION: Person to be receiving requested services

Is applicant aware of referral to ICM ❑ Yes ❑ No **Gender:** _____ **Gender Pronoun:** _____

Indigenous Identity: ❑ Indigenous ❑ Non- Indigenous ❑ Status ❑ Unknown

PHN # (*if known*): _____ **DOB:** _____
(DD/MM/YYYY)

First Name: _____ **Middle Name:** _____

Last Name: _____ **Alias/Preferred Name:** _____

Identifying Features (Height, Tattoos, Hair Colour Etc): _____

_____

No fixed address: ❑ **Family Status:** Single ❑ Couple ❑ Family ❑

Best places to locate Participant: _____

Current Address: _____
(Street) (City) (Postal Code)

Phone #: _____ **E-mail:** _____

PARTICIPANT CONTACT INFORMATION:

Emergency Contact First & Last Name: _____

Phone #: _____ **Relationship:** _____

General Practitioner:

First & Last Name: _____ ❑ **GP** or ❑ **NP**

Phone #: _____ **Fax #:** _____

First & Last Name: _____ ❑ **Psychiatrist**

Phone #: _____ **Fax #:** _____

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PARTICIPANT HEALTH INFORMATION

Current Mental Health Concerns: (Check all that apply)

- ❑ Depression
- ❑ Anxiety
- ❑ ADHD
- ❑ Psychosis
- ❑ Substance induced Psychosis
- ❑ Bipolar
- ❑ Schizophrenia
- ❑ Other: _____

Current Medical Diagnoses and/or Concerns:

- ❑ HIV
- ❑ Hepatitis C
- ❑ Acquired brain injury
- ❑ Developmental Disability
- ❑ Allergy Profile Attached
- ❑ Other: _____

Medication Information:

Please attach if available or current: ❑ MAR and/or ❑ Current Prescription
Otherwise list: (Including known OTC's, herbals, and vitamins)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Does the applicant have chronic or dependent substance use:
Please indicate primary and secondary substance use

❑ Yes ❑ No *If yes:* How long? _____

Drug(s) of choice:	**Primary**	**Secondary**
❑ Heroin	❑	❑
❑ Fentanyl	❑	❑
❑ Methamphetamines	❑	❑
❑ Cocaine	❑	❑
❑ Alcohol	❑	❑
❑ Marijuana	❑	❑
❑ Other:_____	❑	❑

Does the applicant use drugs intravenously?

❑ Yes ❑ No

If yes:

How long? _____

Dosage: _____

How Often: _____

Last Used: _____

Has the applicant ever shared needles?

❑ Yes ❑ No

If yes: How long? _____

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PARTICIPANT INCOME AND HOUSING INFORMATION:

SOURCE OF INCOME:	HOMELESS STATUS
❑ Employment ❑ EI - Employment Insurance ❑ WCB – Workers Compensation Board ❑ IA – Income Assistance ❑ PPMB – Persons with Persistent Multiple Barriers ❑ PWD – Persons with Disabilities ❑ Private Pension ❑ CPP/OAS – Canada Pension Plan/ Old Age Security ❑ Union Disability ❑ PGT – Public Guardian and Trustee ❑ No Income Source ❑ Other: _____	❑ Absolute homeless ❑ Homeless due to crisis ❑ Risk of homelessness ❑ Hidden homelessness ❑ Recently released from corrections ❑ Neither homeless or at risk Reasons _____

Current Housing Situation: _____

Housing History: (Last 2 years): _____

COMMUNITY CONTACTS

History of contacts with mental health care facilities/services (if any):

Date of first contact: _____
(DD/MM/YYYY)

❑ Hospital ❑ Community Mental Health ❑ Substance Use Services

❑ Forensic Services ❑ Community Recovery Houses ❑ Car 67/ Police

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COMMUNITY CONTACTS

Forensic History: (if applicable)

Known Current Police Charges: _____

_____

Forensic Services:

Case Manager Name: _____ Phone #:_____

Probation:

Probation Officer Name: _____ Phone #:_____

Upcoming court date (if applicable): _____

PARTICIPANT INFORMATION HEALTH AND SAFETY CONCERNS

*** Please indicate below any concerns that the service provider needs to be aware of (Attach additional information if needed)**

Risk of Self Harm: ❑ Current ❑ Historical ❑ No History

Risk of Harm to Others: ❑ Current ❑ Historical ❑ No History

History of Overdose: ❑ Yes ❑ No **If yes, how many overdoses: ___ Date of most recent OD:** _____

Interested in Substance Use Treatment: ❑ Yes ❑ No

Details:_____

_____

Currently Engaged in Substance Use Services: ❑ Yes ❑ No If yes, check all that apply

❑ iOAT ❑ Methadone ❑ Suboxone ❑ Kadian ❑ Fentanyl patch ❑ Other : _____

Explain Current Risks and Detail any History of Aggression Towards Staff and Others:

_____

_____

_____

_____

Support Required: ❑ Addiction Services ❑ Counselling ❑ Employment/Volunteer ❑ Health

❑ Maintenance/Housing ❑ Basic Life Skills ❑ Mental Health ❑ Psychiatric Services ❑ Identification

❑ Financial (Specify :_____) ❑ Advocacy (Specify: _____)

❑ Other (Specify :_____)

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REFERRALS FROM FRASER HEALTH/HOSPITAL (Check UCI for community information)

PARIS Referral Form Complete: ❑ **Yes** ❑ **No**

Community Psychiatrist Name: _____ Phone #:_____

Community Case Manager Name: _____ Phone #:_____

Associated Community Team (i.e.: ACSS, SHARP, ASTAT, ICM):_____

If the referral is from the Hospital **Patient Admission Summary Attached:** ❑ **Yes** ❑ **No**

Admit Date to Hospital (DD/MM/YY)**:** _____

Expected Date of Discharge from Hospital (If known) (DD/MM/YY)**:** _____

Inpatient Social Worker: _____ Phone #:_____

Inpatient Psychiatrist: _____ Phone #:_____

Extended Leave upon Discharge: ❑ **No** ❑ **Yes**

Certificate Expiry Date (DD/MM/YY)**:** _____

REASON FOR REFERRAL: ***If referring from another case management team, Explain why the ICM team is better able to support this participant.***

_____

_____

_____

_____

_____

_____

_____

All referrals will be followed up on by an ICM Staff Member.

Please note: A referral does not guarantee acceptance to ICM Services.