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:** _____ **Email Address:** _____

***PARTICIPANT INFORMATION: Person to be receiving requested services***

**Gender:** _____ **Gender Pronoun:** _____

| **ETHNICITY:** | | |
|---|---|---|
| ❑ African | ❑ Arab | ❑ Asian |
| ❑ Caucasian | ❑ Chinese | ❑ Dominican |
| ❑ European | ❑ Filipino | ❑ Hispanic |
| ❑ Jamaican | ❑ Japanese | ❑ Korean |
| ❑ Latin-Central/South | ❑ American | ❑ Vietnamese |
| ❑ West Asian | ❑ Other _____ | ❑ Declined to answer |

**Indigenous Identity:** ❑ Indigenous ❑ Non- Indigenous ❑ Declined to answer

**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:** _____

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## *PARTICIPANT CONTACT INFORMATION:*

**Emergency Contact First & Last Name:** _____

**Phone #:** _____ **Relationship:** _____

❑ **Client consents for ICMT to contact their emergency contact for the purpose of locating client**

**General Practitioner:**

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

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

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

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

## *PARTICIPANT HEALTH INFORMATION*

| **Current Mental Health Concerns:** (Check all that apply) | **Current Medical Diagnoses and/or Concerns:** |
|---|---|
| ❑ Depression | ❑ HIV |
| ❑ Anxiety | ❑ Hepatitis C |
| ❑ ADHD | ❑ Acquired brain injury |
| ❑ Psychosis | ❑ Developmental Disability |
| ❑ Substance induced Psychosis | ❑ Allergy Profile Attached |
| ❑ Bipolar | ❑ Other: _____ |
| ❑ Schizophrenia | |
| ❑ Other: _____ | |

**Medication Information:**

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

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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**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? _____

## *PARTICIPANT INCOME EMPLOYMENT AND HOUSING INFORMATION:*

**SOURCE OF INCOME:**

- ❑ 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: _____

**HOMELESS STATUS**

- ❑ Absolute homeless
- ❑ Homeless due to crisis
- ❑ Risk of homelessness
- ❑ Hidden homelessness
- ❑ Recently released from corrections
- ❑ Neither homeless or at risk

Reasons _____

_____

_____

_____

**Current Housing Situation:** _____

_____

_____

_____

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**Housing History:** (Last 2 years): _____

_____

_____

**EMPLOYMENT STATUS:**

- ❑ Unemployed
- ❑ Lost Job
- ❑ Working Full Time
- ❑ Working Part Time
- ❑ Working Casual
- ❑ Volunteering
- ❑ Other: _____

## *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

**Forensic History:** (if applicable)

Known Current Police Charges: _____

_____

**Forensic Services:**

Case Manager Name: _____ Phone #: _____

**Probation:**

Probation Officer Name: _____ Phone #: _____

Upcoming court date (if applicable): _____

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## *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 :_____)

## *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)**:** _____

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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.***

_____

_____

_____

_____

_____

_____

## *INTENSIVE CASE MANAGEMENT: CONSENT*

### Signatures/Consent:

Has the client been oriented to his/her rights (i.e.: voluntary program)? ❑ **Yes** ❑ **No**

Client consents to being photographed for the purpose of the ICM Team being able to identify/locate them? ❑ **Yes** ❑ **No** **(referral agent will fax photo along with referral package to ICM Team).**

### By signing below, I consent to the following:

This referral is being submitted for consideration to the Langley Intensive Case Management Team The information in this referral and any supporting documentation may be released and shared between my Community Care Team, Substance Use Services Contracted Service Providers and any other health care professional for the purposes of communicating and providing legal, medical and health related information.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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

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