

*Karis Support Society*

\* 1849 Ethel St \* Kelowna B.C. \* V1Y 2Z2 \* Telephone: (250) 860-9507 \* Fax: (250) 860-9517

**Referral Form**

**REFERRAL INFORMATION:**

DATE: \_\_\_\_\_

Referring Agent: \_\_\_\_\_

Email: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

Agency Phone: \_\_\_\_\_

Agency Fax: \_\_\_\_\_

**RESIDENT Information:**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone No: \_\_\_\_\_ Alternative No: \_\_\_\_\_

Care Card No: \_\_\_\_\_ DOB: \_\_\_\_\_ SIN: \_\_\_\_\_

Marital Status: \_\_\_\_\_ No. of Children: \_\_\_\_\_ No of dependent children \_\_\_\_\_

Ages and Names of Children: \_\_\_\_\_

**Emergency Contact Info:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone No: \_\_\_\_\_ Alternative No: \_\_\_\_\_

Relationship: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Mental Health Case Manager: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Alcohol & Drug Counsellor: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Other Professional/Community Supports: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Medical Conditions:**

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**Mental Health Diagnosis:**

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**Medications: (Include dosage)**

**Condition(s) Being Treated:**

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Are any of the following health risk behaviours currently present? (Within the last 6 months.)

	Yes ___	No ___	How often	Last time	How Managing
Seizures	Yes ___	No ___	_____	_____	_____
Suicide attempts	Yes ___	No ___	_____	_____	_____
Self-inflicted violence (e.g. cutting	Yes ___	No ___	_____	_____	_____
Hospitalization for Psychiatric illness	Yes ___	No ___	_____	_____	_____

Does resident have a history of: physical or sexual abuse? \_\_\_\_\_

**ALCOHOL & DRUG USE SUMMMARY:**

Substance Used	Years of use	Date of last use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Other addictions of concern (e.g. gambling, shopping): \_\_\_\_\_

Experience with:	Dates or No of times	Complete	Incomplete
Residential treatment	_____	_____	_____
Supportive Recovery	_____	_____	_____
Detox	_____	_____	_____

Does resident have pending charges, court involvement or probation/bail commitments? No \_\_\_ Yes \_\_\_

Please describe: \_\_\_\_\_

Education: \_\_\_\_\_

Does resident have any special needs (i.e. literacy, disability)? Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe: \_\_\_\_\_

Income: MEIA \_\_\_\_\_ Disability: \_\_\_\_\_ Other: \_\_\_\_\_