1495 Gordon Drive Kelowna, BC V1Y 9R2
Ph: 250-860-2868 Fax: 250-869-1870
www.diversifiedrehab.ca

Mental Health Programs Referral Form

Central Intake Office
Toll Free Fax: 877-869-1870
Email: info@diversifiedrehab.ca

COVID-19 – ONLINE SERVICES

- ☐ Video Individual Counselling Session – PTSD, Anxiety and Depression
- ☐ Video Group Therapy Session – PTSD, Anxiety and Depression

MENTAL HEALTH PROGRAMS – Kelowna, BC:

- ☐ 5-Week Traumatic Stress Recovery Program (TSRP) – First Responder group
- ☐ 5-Week Traumatic Stress Recovery Program (TSRP) – General Public group
- ☐ 10-Day Anxiety and Depression Recovery Program

REFERRAL TYPE:

	Claim / Policy / File # (if applicable)
☐ RCMP	
☐ Veteran's Affair Canada	
☐ Long Term Disability	
☐ WCB	
☐ Private	

REFERRING CLINICIAN / AGENCY:

Name:		Job Title / Specialty:	
Company:		Phone:	
Address:		Fax:	
City		Email:	
Province		Postal Code:	

CLIENT INFORMATION:

Last Name:		Health Card #	
First Name:		Date of Birth:	
Address:		Primary Language:	☐ English ☐ Other
City		Pre-Disability Occupation:	
Province		Date of Disability:	
Postal Code:		Phone #:	
Email:			
Injury/Illness:			

REFERRAL INFORMATION:

Primary Reason for Referral:

In order to arrange a timely admission, please provide us with any relevant medical/clinical information. Copies of past assessments, consults, tests results and discharge summaries are very helpful.

Is the client an urgent referral? ☐Yes ☐No Is the client aware of this referral? ☐Yes ☐No

Significant Medical History (list all applicable conditions):

_____

_____

_____

Check all that apply:

More than 6 months	Last 6 months	Primary concern	Condition	More than 6 months	Last 6 months	Primary concern	Condition
☐	☐	☐	PTSD, Abuse or Trauma	☐	☐	☐	Chronic Pain
☐	☐	☐	Anxiety	☐	☐	☐	Cognitive Disorder
☐	☐	☐	Depression	☐	☐	☐	OCD
☐	☐	☐	Bipolar	☐	☐	☐	Personality Disorder
☐	☐	☐	Suicide attempts	☐	☐	☐	Other:

Current Risk Assessment – check all that apply:

☐ Current active suicidal thoughts
☐ Current passive suicidal thoughts
☐ History of suicide attempts
Date of last attempt:_____

☐ Current thoughts of harm to others
☐ History of violence towards self (self harm)
☐ History of violence toward others

Any additional details regarding above:

_____

_____

_____

HISTORY OF ADDICTION/SUBSTANCE:

In order to be considered for our mental health programs, the client MUST be free of any substance use for a minimum of 30 days prior to admission.

Is the client currently free of substance use? ☐Yes ☐No

History of any drug or alcohol/substance use? ☐Yes ☐No

If Yes, please comment on type of substance, length of use and treatment:

_____

_____

Additional Information:

Does the client use medical marijuana? ☐Yes ☐No

REQUIRED DOCUMENTS MUST BE ATTACHED WITH REFERRAL:

☐ Funding Approval Memorandum attached
☐ Medical / Background Documents attached
☐ Prescription for Medicinal Marijuana
☐ Medication list attached (name, dosage, frequency, reason for use)
☐ Other: _____

Notes: _____

_____

_____

Signature: _____ **Date:** _____