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| **TRANSITIONS PROGRAM REFERRAL** |
| Service Requested:[ ]  Withdrawal Management (7-10 days)[ ]  Supportive Recovery (up to 3 months) |  |
| Referred by: |  | Date of Referral: |   |
| Team/Org/Agency or Self: |   |  | (dd/mm/yy) |
| Phone: |   | Fax: |   | Email: |  |
| **1. Youth & Family Information:** |
| Youth Name: |  | Birth Date: |  | Age: |  |
| Gender: | [ ] F [ ] M [ ] Non-Binary [ ] Other: |  | PHN: | (dd/mm/yy) |  |
| Address: |   |
| Main Phone: |   | Alt. Phone: |   |
| Caregiver: |  | Relationship: |  |
| Phone: |  | Email: |  |
| **2. Other Professionals Involved:** |
| Name: | Role/Relationship: | Phone/Fax: |
|   |   |   |
|   |   |   |
|   |   |   |
| **3. Substance Use:** Please describe past or current substance use. Current substance use? Y[ ]  N [ ]  |
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| **4. Presenting Concerns:** | Please identify client strengths/resiliencies that will assist with success in the program. |
|   | **i.**   |
| **ii.**  |
| **iii.**  |
| **5. Risk Factors & Safety Concerns:** |
| [ ]  Mental health considerations[ ]  Suicidal ideations[ ]  Self-harm[ ]  Significant medical needs[ ]  Legal issues[ ]  Violence/aggression[ ]  AWOL/flight risk | If present, please describe:  |
| If risk factors are present, is there a safety plan? Y [ ]  N [ ]  |
| Follow up date: |   | Staff: |   |
|  | (dd/mm/yy) |  |  |
| **6. Additional Information:**  Please detail any additional information that may impact the referral, if applicable. |
|   |
| **7. Verification & Consent:** Please ensure the referral is complete, correct and that the person referred is aware of the referral, and if possible, has provided consent. |
| Consent for referral provided by person(s) being referred: Y[ ]  N [ ]  |
|   | Date: |   |
| Signature of person(s) being referred or indicate verbal consent |  | dd/mm/yy |
|   | Date: |   |
| Signature of referring person |  | dd/mm/yy |
| Please fax signed and completed referrals to: 250-754-1605Please do not email. |