**SOUTHERN ALBERTA SELF-HELP ASSOCIATION**

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# REFERRAL PACKAGE

## Client Information

**CLIENT Name:** _____ **Gender:** -------- **PHN #** _____

**Birth Date:** _____Home Address: _____

City/Town: _____ **Postal Code**: _____ Client Phone #: _____

Psychiatrist: _____ Phone #: _____ Physician: _____ Phone #: _____

**Mental Health Therapist/ Case Manager:** _____**Phone:** _____

STATUS: Independent ☐ Guardianship ☐ Trusteeship ☐ Personal Directive ☐ (attach personal directive or id. location)_____

**Primary Contact (next of kin): NAME:** _____ Phone #: _____ Relationship:_____

## Referral Information

REFERRAL Source Name: _____ Referral Contact Name: _____

Contact Name Phone #: _____ Date requesting housing: _____

## Placement Information

**Type of Placement Required:** ☐ Respite ☐ Transitional ☐ Long Term Is the client on CTO ☐ Yes ☐ No

**Why are you requesting this placement?** _____

**Method of payment for this support: Self** ☐ Social Assistance ☐ Pension ☐ AISH ☐ Other (describe): _____

**Other Information ethically needing to be considered in best interests of the client/placement and potential peers:** _____

## PERSONAL HEALTH INFORMATION

| | | Comments |
|---|---|---|
| **Diagnosis of Mental Health** | | |
| **Addictions** | | |
| **Condition/Risks requiring attention and/or CAUTIONS** | | |
| **General History of Health/Wellness (Medical Issues)** | | |
| **Allergies** | | |
| **Motivation** | | |

## CURRENT MEDICATIONS LIST:

| Name | Dosage | Frequency | Side Effects Experienced: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## MENTAL HEALTH PROGRAM: PSYCHOSOCIAL & FUNCTIONAL SKILLS ASSESSMENT PROFILE

CLIENT Name: _____ Assessment Date: _____

- **Please comment on the following areas with respect to how it affects client functioning and independence.**

### Cognition:

**Memory: (Appointment times; instructions; chores)**

**Judgment: (Impulsive, clear)**

**Decision-making: (Food/clothing choices)**

**Problem Solving: (Who to call in emergency, when sick)**

**Social Interactions/behaviors**

**Sociability**

**In/appropriate Social Behaviors:**

**Communication Ability**

**Language (other than English; comprehension problems; listening)**

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**Meal Preparation:**

**Time Management:**

**Efficiency; Speed of Work:**

**Involvement in Activity:**

**Responsibility:**

**Budgeting/Money Management:**

**Hygiene Management:**

### Emotional State

**Affect (Labile/Flat):**

**Expression of Emotions (Temper/Frustration Tolerance/Agitation):**

**Values, Beliefs or Practices needing consideration:**

**Has a summary of Mental Status or Psychiatric Assessment been included in the referral? Yes ☐ No ☐**

# CLIENT REFERRAL PACKAGE

## INDIVIDUAL SERVICE PLAN (ISP)

**Client Name: _____**

| **CLIENT requires support in the areas identified as follows: SERVICE REQUIREMENTS/EXPECTATIONS** include but are not limited to: | **Yes/No/N/A as appropriate** | **For additional Requirements /Expectations use back** |
|---|---|---|
| (a) Maintain **communication with the Mental Health Therapist/ Case Manager** with respect to progress in achievement of goals. | ☐ Yes ☐ No ☐ N/A | |
| (b) To assist in **locating suitable accommodation** that will enhance functioning. | ☐ Yes ☐ No ☐ N/A | |
| (c) Assist in **planning the move and obtaining adequate furnishings**. | ☐ Yes ☐ No ☐ N/A | |
| (d) Encourage and assist in **maintaining or improving health** (i.e. general medical, dental and other health and wellbeing appointments). | ☐ Yes ☐ No ☐ N/A | |
| (e) Monitor (not administer) **medication** according to policy and under the direction of the Case Manager as outlined in the ISP. | ☐ Yes ☐ No ☐ N/A | |
| (f) Encourage and assist in opportunities to improve **money management** skills (i.e. budgeting, banking and payment of bills etc.). | ☐ Yes ☐ No ☐ N/A | |
| (g) Encourage knowledge and skill development in the areas of grocery shopping, **meal planning and preparation** and housekeeping etc. | ☐ Yes ☐ No ☐ N/A | |
| (h) Assist and encourage in **organization of time** | ☐ Yes ☐ No ☐ N/A | |
| (i) Encourage awareness and use of **community resources (i.e. bus routes**, taxis, stores, malls, banks, church, recreational and other services etc.). | ☐ Yes ☐ No ☐ N/A | |
| (j) Encourage skills development required to maintain accommodation reasonably organized, clean and tidy and coach with respect to **domestic skills routines.** | ☐ Yes ☐ No ☐ N/A | |
| (k) Assist in **maintaining and/or improving hygiene** skills and other personal care. | ☐ Yes ☐ No ☐ N/A | |
| (l) Coach with respect to skill and desire to maintain **clean and seasonally appropriate clothing**. | ☐ Yes ☐ No ☐ N/A | |
| (m) Coach with respect to taking advantage of opportunities for **integration in community** (i.e. socializing and volunteering in support associations etc.) | ☐ Yes ☐ No ☐ N/A | |
| (n) Encourage/assist with respect to **constructive day activities** and employment/ volunteering | ☐ Yes ☐ No ☐ N/A | |
| (o) Coach with respect to benefits of **leisure and recreational** activities. | ☐ Yes ☐ No ☐ N/A | |
| (p) Assist with accessing **personal identification** documentation. | ☐ Yes ☐ No ☐ N/A | |
| (q) Assist in dealing with **legal** and other issues. | ☐ Yes ☐ No ☐ N/A | |

**Client's Main Goals for Service:**

**Client Signature: _____ Referral Signature: _____**

# CONSENT TO DISCLOSE PERSONAL INFORMATION

## CONSENT TO DISCLOSE PERSONAL INFORMATION

**FOR INDIVIDUAL**

I, _____ of _____
(Name of client/patient and date of birth – please print) (Address)

Give consent to the staff of _____ to disclose the following health information (list specifically
(Name of service provider – facility, clinic, agency, service contractor or committee)

What information is to be disclosed): _____
_____

To: _____
(Name of service provider - agency)

**FOR SUBSTITUTE DECISION-MAKER**

I, _____, the _____ on behalf of
(Name of substitute decision-maker – please print) (Identify legal status, e.g. parent/guardian/agent)

_____ give consent to staff of _____
(Name and date of birth of client/patient – please print) (Name of service provider – faculty, clinic, agency, service contractor or committee)

To disclose the following information (list specifically what information is to be disclosed): _____
_____

To: _____
(Name of service provider – agency)

I understand the reason for disclosing this information is: _____

_____.

I confirm that I was told why the information is needed and the risks and benefits to _____ of consenting to disclose or refusing to disclose the information.

I also confirm that I was told and understand that I may cancel this consent in writing at any time, and no further information would be disclosed unless required by law.

This consent is effective from the _____ day of _____, 20___, until

_____ day of _____ 20____.
(Recommended standard is 90 days.)

_____ _____
(Signature of client or substitute decision-maker) Date

_____ _____
(Name of witness – please print) (Signature of witness)

A photocopy or facsimile signed by the individual/substitute decision-maker is deemed as valid as the original.

RESET SAVE PRINT



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