

# GAPPS REFERRAL FORM

## Getting Appropriate Personal & Professional Supports

**Client Name:** \_\_\_\_\_ **Referral Date:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Gender:** Male  Female   
**Address:** \_\_\_\_\_ **Family Physician:** \_\_\_\_\_  
 \_\_\_\_\_ **Health Card No.:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

### **REFERRAL ISSUES:**

- Client is a person with a very serious, unstable and complex mental health or addictions issue who is currently **NOT ACCESSING ANY SERVICES**.
- There is evidence of past difficulty in benefiting from existing services.

<b>Services used in the PAST YEAR</b>	<b>TBRHSC</b>	Emergency Dep't <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Number of ER Visits: _____	<b>Case Management Services:</b>
	<b>SJCG</b>	Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Specify SJCG Services: _____	<b>Other:</b>

### **CONCERNS:**

<b><u>MENTAL HEALTH</u></b> <input type="checkbox"/> Mood Problems <input type="checkbox"/> Anxiety Problems <input type="checkbox"/> Psychosis <input type="checkbox"/> Personality Problems <input type="checkbox"/> Other _____	<b><u>SUBSTANCE ABUSE</u></b> <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Polysubstances <input type="checkbox"/> Gambling <input type="checkbox"/> Other _____	<b><u>PSYCHOSOCIAL</u></b> <input type="checkbox"/> Unemployment <input type="checkbox"/> Financial Issues <input type="checkbox"/> Legal Issues <input type="checkbox"/> Housing <input type="checkbox"/> Other _____	<b><u>MEDICAL/PHYSICAL</u></b> <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Medication Issues <input type="checkbox"/> Medical/Physical/Cognitive Illness/Disability (List): _____
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<b>Client Identified Need?</b>     	<b><u>REFERRAL SOURCE:</u></b> <input type="checkbox"/> Mental Health <input type="checkbox"/> Addictions <input type="checkbox"/> Health <input type="checkbox"/> Social Service <input type="checkbox"/> Justice <input type="checkbox"/> Self / Family <input type="checkbox"/> Other _____
Name of Facility/Program/Agency/Clinic <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	
<b>(Please Print Name &amp; Phone Number)</b>	

**Please fax/mail or if you have any questions or concerns**



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