DIVERSEcity community resources society

CLIENT REFERRAL FORM

Mental Health, Substance Use & Violence Prevention Services

Effective September 28, 2020

DIVERSEcity Office Use Only

Referral Received Date:
Screening Completion Date:
Staff Assigned:

Assigned By:
Date Assigned:

Section 1: Client Information

Client's Name (First and Last Name):

Gender:

Date of Birth:
DD/MM/YYYY

Phone:
Can we leave a message? ☐ Yes ☐ No
Email:

Address:

City:

Province:

Postal Code:

Preferred Language of Service:

Cultural Background:

How comfortable is the client with service in English?

- ☐ Not comfortable at all
- ☐ Slightly comfortable
- ☐ Comfortable
- ☐ Very comfortable

Section 2: Reasons for Referral

Support is required in the following areas: (*Please check all that apply*)

- ☐ Depression
- ☐ Anxiety
- ☐ Trauma
- ☐ Substance use and/or addiction
- ☐ Settlement issues
- ☐ Family conflict and/or violence
- ☐ Connection and relationships
- ☐ Parenting
- ☐ Attachment
- ☐ Discrimination
- ☐ Suicidality
- ☐ Homicidality
- ☐ Self-harm
- ☐ Outreach and accompaniment
- ☐ Legal issues
- ☐ Other

Please share any other relevant information for the reason for referral:

Section 3: Referral Source Information

(Please do not fill out this section if you are self-referring.)

Name:

Relationship to client:

Agency (if applicable):

Phone:

Email:

Do you require notice of intake and assignment? ☐ Yes ☐ No

Please confirm that the client has consented to this referral: ☐ Yes ☐ No

If not, please explain:

How did you hear about our services?

Referral Guidelines

- Incomplete forms will not be accepted.
- A referral does not guarantee service. All referrals are screened at intake.
- If you require notice of intake and assignment, the client's consent will be required to notify you of the name of the assigned staff and anticipated start date.
- Please note that any additional information sharing requires a client's consent.
- Please email completed form to **intake@dcrs.ca** or fax to **604-597-0488**.