BOREAL WELLNESS CENTRES

COMPASSION. DEDICATION. INNOVATION.

REFERRAL FORM FOR ADMISSION

www.BorealWellness.com | 778.725.0714 ext. 103

Date of Referral: _____

Referral Form Filled Out By: Client (self-referral) ☐ Physician ☐ Therapist ☐ Other ☐

Program(s) of Interest: Day Treatment ☐ Trauma Day Treatment ☐ Evening IOP ☐
Individual Therapy ☐ Evening Skills Workshop ☐

CLIENT DEMOGRAPHIC INFORMATION:

Client Name: _____ DOB (YYYY/MM/DD): _____

Client Care Card / Personal Health #: _____

Client Email: _____ Client Mobile: _____

Messages Can Be Sent Via / Left On Client's: ☐ Email ☐ Mobile Text ☐ Mobile Voicemail

Address: _____ City: _____ Postal Code: _____

Emergency Contact Name #1: Emergency Contact Phone #: Relationship To Client:

_____ _____ _____

Currently Employed? Employer: Open Disability Claim?

☐ Yes ☐ No _____ ☐ Yes ☐ No

[For physician offices, this space can be used to apply a label with patient demographic information]

MEDICAL, PSYCHOLOGICAL & PSYCHIATRIC HISTORY:

Family Physician:	City:	Phone:
_____	_____	_____
Psychiatrist:	City:	Phone:
_____	_____	_____
Psychologist:	City:	Phone:
_____	_____	_____

Any psychiatric and/or medical hospitalizations? ☐ Yes ☐ No

If 'yes', when, where and why? _____

Able to participate in a group based program? ☐ Yes ☐ No

Does the client have? ☐ Cognitive Limitations ☐ Learning Disabilities

Any current or anticipated involvement in legal action related to their health? ☐ Yes ☐ No

List of all medications that client is currently taking:

Name of Medication:	Dosage:	Prescribed for:	Prescribing Physician:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does client take prescribed opiates (e.g. codeine, methadone)? ☐ Yes ☐ No

If 'yes', ☐ for pain, ☐ for addiction

PRESENTING CONCERNS:

Primary reason for referral: _____

Please: 1) check all concerns; and 2) mark the primary concern.

In Last 6 Months	Prior To 6 Months Ago	Primary Concern	
☐	☐	☐	Eating Disorder
☐	☐	☐	Acute Psychosis (thought disorder, hallucination, delusion)
☐	☐	☐	Chronic Psychosis
☐	☐	☐	Chronic Pain
☐	☐	☐	History of Abuse or Trauma
☐	☐	☐	PTSD (post-traumatic stress disorder)
☐	☐	☐	Self-Harm (e.g. cutting, burning self)
☐	☐	☐	Suicide Attempts
☐	☐	☐	Dissociative Identity Disorder
☐	☐	☐	Personality Disorder
☐	☐	☐	Dementia
☐	☐	☐	Schizophrenia
☐	☐	☐	Bipolar Disorder
☐	☐	☐	Major Depression
☐	☐	☐	Mania
☐	☐	☐	Violence
☐	☐	☐	Aggression
☐	☐	☐	ADHD
☐	☐	☐	Healthy Anxiety
☐	☐	☐	Panic Disorder
☐	☐	☐	Obsessive Compulsive Disorder (OCD)
☐	☐	☐	General Anxiety Disorder
☐	☐	☐	Agoraphobia
☐	☐	☐	Other Phobia(s): _____
☐	☐	☐	Dissociation
☐	☐	☐	Cognitive Disorder (head injury, memory problems)
☐	☐	☐	Substance Mis-Use
☐	☐	☐	Other: _____

If there are currently any substance mis-use problems, please fill in the following:

#1 Substance of Choice _____ Years of Use: _____ Amount Per Day: _____

#2 Substance of Choice _____ Years of Use: _____ Amount Per Day: _____

Does the client admit to having a drug or alcohol problem? ☐ Yes ☐ No

If the client currently has PTSD, please indicate all types of trauma they have experienced:

☐ Violence ☐ Accident ☐ Occupational ☐ Military ☐ Childhood ☐ Other _____

Current Safety Risks

- ☐ Wandering Risk
- ☐ Self-Harm / Violence Towards Self
- ☐ Current Passive Suicidal Thoughts
- ☐ Current Active Suicidal Thoughts
- ☐ History of Suicide Attempts / Date of Last Attempt: _____
- ☐ Risk of Falling
- ☐ Current Thoughts of Harm To Others
- ☐ History of Violence Towards Others / Property
- ☐ History of Fire Setting

Please provide additional details regarding risks identified above:

Please list any medical difficulties or illnesses experienced, including hospitalizations, surgeries and other forms of treatment.

Problem:	Date:	Treatment:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please also indicate any other information that was not asked above but that you believe would be important for a treatment provider to know.

Signature: _____ Date: _____

Please send Referral Forms to info@BorealWellness.com or fax to (833) 303-3736. We will contact you once a decision has been made regarding the fit with our programming. If there is a fit, the next step would be a psychological assessment by a psychologist. If you have any questions, please contact us at 778.725.0714.