Better Morning - Adult Day Rehabilitation Service

Referral Form

SECTION 1: REFERRAL DETAILS

- Date of Referral:
- Referral Source:
  - Name:
  - Organization (if applicable):
  - Position/Role:
  - Contact Number:
  - Email Address:
- Relationship to Client:(e.g., self, family, doctor, social worker, etc.)

SECTION 2: CONSUMER INFORMATION

- Full Name:
- Date of Birth:
- Gender:
- Address:
- Phone Number:
- Email Address:
- Preferred Method of Contact: (Phone, Email, Mail)
- Emergency Contact Person:
  - Name:
  - Relationship to Client:
  - Phone Number:

SECTION 3: MENTAL HEALTH HISTORY

- Primary Diagnosis:
- Secondary Diagnosis (if applicable):
- Current Mental Health Symptoms (check all that apply):

Anxiety ☐

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Depression ☐

Psychosis ☐

Mood Swings ☐

Suicidal Ideation (current or past) ☐

Self-Harm ☐

Other (please specify):

- Duration of Mental Health Issues:
- Previous Mental Health Treatment: (Please include type of treatment, dates & outcome)
- Hospital Admissions (if any):
- Date(s):
- Reason(s):

SECTION 4: FUNCTIONAL ASSESSMENT

Cognitive Functioning (check all that apply):

Memory Issues ☐

Attention/Concentration Issues ☐

Executive Functioning Challenges ☐

- Other Cognitive Difficulties (please list):

Daily Living Skills:

- Ability to perform activities of daily living (e.g., hygiene, cooking, shopping):

Yes ☐

No ☐

- Level of independence:
- Needs for assistance (please specify):

Social Functioning:

- Current social support system (e.g., family, friends, support groups):
- Any issues with social isolation or withdrawal:
- Communication difficulties:

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SECTION 5: CURRENT MEDICATIONS

Current Medications:

- Medication 1:
- Dosage:
- Frequency:

- Medication 2:
- Dosage:
- Frequency:

Prescribing Physician/Psychiatrist:

- Name:

- Contact Information:

Allergies (if any):

Medication Compliance: (Fully compliant, Partially compliant, Non-compliant)

SECTION 6: SUBSTANCE USE HISTORY

Substance Use History:(Alcohol, Drugs, Prescription Medication Misuse)

- Substance(s):

- Frequency and duration of use:

- Previous treatment for substance use (if applicable):

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SECTION 7: GOALS FOR DAY REHABILITATION

Reason for Referral:

- (Why is the client being referred to mental health day rehabilitation?)

- Client's Treatment Goals:

- (What does the client hope to achieve through rehabilitation?)

- 1.

- 2.

- 3.

SECTION 8: RISK ASSESSMENT

Current Risk Factors:

- Suicidal ideation/intent
- History of self-harm
- Violent/aggressive behavior
- Substance misuse
- Vulnerability or risk of exploitation

Risk Management Plan:

- (What actions have been taken to manage the risks identified?)

SECTION 9: ADDITIONAL INFORMATION

Previous Day Rehabilitation Participation:

- (Has the client previously attended day rehabilitation programs? If yes, provide details)

Other Relevant Information:

- (Any other details that might assist in understanding the client's needs)
- E.g., cultural considerations, family dynamics, support network involvement

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SECTION 10: CONSENT

Client Consent for Referral:

- I, (Consumer's Name:), consent to the referral to the mental health day rehabilitation program and understand the nature of the program.

- I, (Consumer's Name:), authorize the release of my medical information to the mental rehabilitation provider.

- Consumer's Signature: ________________________
- Date: ________________________

-Referrer Signature:

- Referrer Name: ________________________
- Date: ________________________

For Office Use Only:

Received by: Name: ____

Signature: ____

Date:________________________________

Referral Processed by: Name: ______________________________

Signature: ____

Date: __________________________________

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