Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

Facility: _____

File: _____

Last name, first name: _____

Date of birth: _____ ☐ F ☐ M
yyyy-mm-dd

RAMQ no.: _____ Exp. _____
yyyy-mm

Mother's name: _____

SERVICE REQUEST – YOUTH AND ADULT REFERRAL TO THE CRD

SERVICE REQUEST:
☐ YOUTH* (age 17 and under) ☐ ADULT

PREFERRED LANGUAGE:
☐ FRENCH ☐ ENGLISH

☐ REFERRAL BY THE DIRECTOR OF YOUTH PROTECTION (DYP), including the YOUTH CENTRES
Youth campus – UNIT *(where applicable)*: _____
Address: _____

IDENTIFICATION OF REFERRING PERSON

Last name: _____ First name: _____
Organization : ☐ Liaison CHCLM ☐ Liaison CHPB ☐ Liaison CHAL Phone: _____
Other professionals involved: _____ _____
(Last name) (First name)

SECTION RESERVED FOR THE LIAISON NURSE

Department : ☐ 221 Physical emergency ☐ 223 Youth psychiatric emergency ☐ 225 Physical health care unit
☐ 222 Psychiatric emergency ☐ 224 Mental health care unit ☐ 226 Other hospital unit
Specify : _____

COMMENT:

PATIENT IDENTIFICATION

Address: _____
City: _____ Postal code: _____
Email: _____
Phone no. - home: _____ ☐ Authorization to leave a message ☐ Yes ☐ No
Phone no. - work: _____ ☐ Authorization to leave a message ☐ Yes ☐ No
Cell no.: _____ ☐ Authorization to leave a message ☐ Yes ☐ No

ADDITIONAL INFORMATION ABOUT THE USER

Father's name : _____ _____
(Last name) (First name)
Native language: _____ Place of birth: ☐ Québec ☐ Other Specify : _____
Emergency contact: _____ _____
(Last name) (First name)
Email: _____ Relationship with user: _____
Phone no.: _____ Cell no.: _____

CIVIL STATUS

☐ Single ☐ Common-law ☐ Divorced ☐ Married
☐ Separated ☐ Widow(er) ☐ Other: _____

Have you ever received services from the CRD of the CISSSMO (Virage or Foster): ☐ Yes → Write the name of the point of service: _____ ☐ No

Last name, first name: File no.:

OCCUPATION (adult section)

☐ Looking for a job ☐ Full-time studies/training ☐ Part-time studies/training
☐ Full-time work (35+ h/week) ☐ Part-time work (< 35 h/week) ☐ Volunteering
☐ Sick leave, parental leave, strike ☐ Detained ☐ Homeless
☐ Seasonal worker on leave ☐ Disability/Inability to work ☐ Retired
☐ Homemaker ☐ Other: _____

LIVING SITUATION

☐ Living with one or several relatives ☐ Living with one or several non-related persons *(foster home, youth centre, etc.)*
☐ Single-parent ☐ Couple with child(ren) under 18 ☐ Couple without children ☐ Person living alone

REFERRED USER'S PROBLEM

☐ Alcohol ☐ Drugs ☐ Medications ☐ Gambling ☐ Cyber-dependence ☐ Entourage

SCREENING TOOLS (attach to form)

☐ DEP-ADO ☐ DÉBA Alcool ☐ DÉBA Drogue ☐ DÉBA Jeu

_____ Score _____ Score _____ Score _____ Score

USER'S AVAILABILITY

☐ Morning ☐ Afternoon ☐ Evening

DECISION FOLLOWING ANALYSIS

☐ Client abandons before analysis
☐ Oriented towards : Other network mission
☐ Oriented towards CLSC
☐ Formal referral towards a private or community resource

SECTION RESERVED FOR THE LIAISON NURSE

☐ Accepted
☐ Oriented towards: CH, CHSGS, SHPSY
☐ Formal referral towards: volunteer, community or social economic resource
☐ Client's refusal
☐ Ineligible (refused)
☐ Oriented towards: Youth Centre
☐ Formal referral towards another CRD
☐ Treated and completed

COMMENT:

AUTHORIZATION TO EXCHANGE INFORMATION

I authorize _____ to send this referral form, the completed screening tools, and all information related to the referral to the CISSS de la Montérégie-Ouest's Centre de réadaptation en dépendance (CRD).

I authorize the referring healthcare professional to exchange information about this referral with the healthcare professional at the CISSS de la Montérégie-Ouest's Centre de réadaptation en dépendance (CRD).

THIS AUTHORIZATION IS VALID FOR 90 DAYS

I understand that I may change or cancel this authorization at any time.

_____ _____
Signature of user or legal representative yyyy-mm-dd

_____ _____
Signature of referring healthcare professional yyyy-mm-dd

PLEASE SEND THE SIGNED FORM AND A COPY OF THE COMPLETED SCREENING TOOL TO THE CRD'S CENTRALIZED INTAKE DEPARTMENT OF THE CISSS DE LA MONTÉRÉGIE-OUEST

Montérégie (French – English)	**Montréal** (English)
Fax: **450-443-0522**	Fax: **514-486-2831**
Email: **accueil.dependance.cisssmo16@ssss.gouv.qc.ca**	Email: **accueil.montreal.dependance.cisssmo16@ssss.gouv.qc.ca**

FOR MORE INFORMATION, CALL THE CENTRALIZED INTAKE DEPARTMENT

Montérégie (French – English)	**Montréal** (English)
Phone no.: **450-443-4413** Toll-free: **1-866-964-4413**	Phone: **514-486-1304** Toll-free: **1 866 851-2255**