Centre intégré
de santé
et de services sociaux
des Laurentides
Québec

DT6069

REFERRAL FORM
FOR LOCAL SERVICES

1. IDENTIFICATION

Family name :		First name :			
Date of birth :		Age :		Telephone :	
Address :				Postal code :	
Father's family name :		First name :			
Date of birth :		Email :		Telephone :	
Address :				Postal code :	
Mother's family name :		First name :			
Date of birth :		Email :		Telephone :	
Address :				Postal code :	
Attending physician :					
Pharmacy contact details :					
Name of school :					

Lives with : ☐ Father ☐ Mother ☐ Father and Mother ☐ Alone ☐ Other

2. BRIEF DESCRIPTION OF THE CURRENT SITUATION *(reason for referral / triggering event / diagnosis related to the request)*

3. OPINION OF REFERRER REGARDING LEVEL OF RISK AND VULNERABILITY

4. NEEDS IDENTIFIED

By the user :

By the user's family :

By the referrer :

User's family name, first name : Date of birth : File # :

5. ACTIONS PUT IN PLACE AND SERVICE HISTORY

6. CONSUMPTION (Drug – Alcohol – Gaming – Medication) ☐ Yes ☐ No ☐ Not evaluated

(attach assessment grids if applicable)

7. CONSENT

a) Has the user aged 14 or older been informed of the request ? ☐ Yes ☐ No, if not, why ?

Legal custody : ☐ Father ☐ Mother ☐ Other

Protection regime : ☐ Curator ☐ Guardian ☐ Incapacity mandate

b) If applicable, have the legal guardians (e.g. parents) been informed of the request ? ☐ Yes ☐ No, if not, why?

c) Is the user capable of understanding this request for services? ☐ Yes ☐ No, if not, why?

8. COMMENTS

☐ Attach pertinent reports and assessments as well as intervention plans (if available, attach pharmacological profile)

Please enter the following information in block letters

Date	Name of referrer/title	Institution	Telephone number/extension

Signature : _____

AUTORIZATION TO SHARE USER'S INFORMATION ☐ Yes ☐ No