RASS Richmond Addiction Services Society

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Richmond, BC V6Y 0J5
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Aging Well Program **Referral Form for Professionals** **HIGH PRIORITY ☐**

Date: ______________________ Client living / working in Richmond ☐ **Yes** ☐ **No**

Client Name (Last Name, First Name):_______________________________ Gender:_____ D.O.B. ______________

Address: ____ E-Mail:______________________________

Care Card #: __________________________ Referrer Name: ______________________________

Referrer Organization: _______________________________

Referrer Phone Number: ______________________________

Client's First Language: ________________________ Client's Ethnicity/Cultural Group: ____________________

Client's Cell #:______________________________ ☐ Call OK? ☐ Message OK?

Client's Home#:___________________ ☐ Call OK?☐ Msg. OK? Other# _____________☐Call OK? ☐Msg. OK?

Client's Emergency Contact Name and #: ____

Reason for Referral: ____

____

Gambling / Internet: game of choice			
Drug of choice & how used (smoke, inject, freebase, etc).			
Amt/frequency of use/gambling & # years of use/gambling			
Date last used/gambled :			

2) SUICIDE RISK? ☐**Yes** ☐**No** Action taken: ___________________________________

3) Mental Health Concern? ☐**Yes** ☐**No**______________ Connected to RMH: ☐**Yes** ☐**No** Worker/Dr: ___________

4) Medications: ____

5) Professionals Involved: ____

6) Marital Status/Relationship: ________________ 7) Work Status/Income Source: ________________

8) Living Situation: _______________________ 9) Children: ___ Live with Client? ☐Yes ☐No

10) Immediate housing required? ☐ **Yes** ☐ **No** Recommendations: ________________________________

11) Living with someone with a substance problem: ☐Yes ☐No Recommendations: ______________________

12) Any language/medical/physical barriers that require assistance in the treatment process?: ________________

13) Concern for Complicated Withdrawal: ☐Yes ☐No. Action Taken: ___________________________________

14) Other Immediate Referral Made**:** ____

This client consents to receiving contact from Richmond Addiction Services.

Referrer's signature: ____