



CRISIS OUTREACH – PROGRAM CRITERIA

Client must have ALL of the following:

- Client is aware of this referral and is agreeable to service
- Client is experiencing challenges with mental health and/or substance use
- Client is deemed safe to be seen in the community by a single staff

Choose at least one - check all that apply

- Has multiple recent hospitalizations/ ED visits
- Requires immediate short-term support in stabilization of mental health and/or substance use
- Is sober but is at a high risk of imminent relapse
- Is chronically suicidal and has had a change in baseline risk behavior

Please note: this is NOT an emergency service – referrals should expect contact within 48 hours

Referral Source:	Contact Name:	Contact Number:
Client is aware of this referral and is agreeable to service: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Client surname:		Given name(s):	
Health Card number:	Birthdate: DD/MM/YYYY	Age:	Gender/ Pronouns:
Address:		City:	Postal Code:
Phone:	Leave voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can identify service on v/m? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location at time of referral: <input type="checkbox"/> Hospital <input type="checkbox"/> Shelter <input type="checkbox"/> Residential Withdrawal Management Centre <input type="checkbox"/> Community			
Anticipated Discharge Date, if applicable: DD/MM/YYYY			
Other supports involved:			
Mental health / Addictions concerns: Details/ Diagnosis:			
Currently suicidal? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:	Previous suicide attempts? <input type="checkbox"/> Yes <input type="checkbox"/> No	History of aggression? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:	

Reason for Referral:
Hospital referrals: please attach patient consultation notes