Homewood Health

Referral Form for Treatment

Reset Form

Date of Referral _____

Section 1: Preferred Referral Location

Homewood Health Centre – Guelph, Ontario ☐

Homewood Ravensview – Victoria, British Columbia ☐

The Residence at Homewood – Guelph, Ontario ☐

Therapy@Home - Virtual Outpatient Services ☐

Please note, all inpatient facilities are tobacco free

Section 2: Referrer Information

Your Name: _____ Phone Number _____ Ext: _____

Your Health Care Discipline (e.g. Family Medicine, Social Worker): _____

Physician Billing #/NP Billing # (if applicable): _____

Agency (if applicable) e.g. WSIB, DND, VAC: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Country: _____

Fax Number: _____ Email: _____

If you are from a Health Care Discipline, will you provide post discharge care: ☐ Yes ☐ No

Section 2a: Complete only if this referral is from RCMP Health Service or from Veteran's Affairs Canada

Is the Member you're referring currently receiving services from an Operational Stress Injury (OSI) Clinic? Yes ☐ No ☐

If yes, please complete the following information:

OSI Provider Name & Designation): _____

Provider Contact information (phone & email): Phone: _____ Email: _____

How many years has the Member been receiving services from the OSI: _____

Section 3: Client/Patient Demographic Information:

Client/Patient Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Country: _____

Phone Number: _____ Alternate Phone Number: _____

Email Address: _____ Health Card #: _____

Department of National Defence Blue Cross Service # (if applicable): _____

Veterans Affairs Canada K# (if applicable) _____

Workers Compensation Board # (e.g. WSIB, WCB, Worksafe BC): _____

All forms and copies of past records and reports should emailed soon as possible to:
Admission Department, Homewood Ravensview, 1515 McTavish Rd., North Saanich, BC
Email: ravensviewreferral@homewoodhealth.com | Fax: 1-855-895-0666

We will contact you once a decision has been made regarding admission. If you have any questions, please contact our Intake Team at 1-866-203-1793 or 250-999-2768. We are typically available (excluding holidays) Monday to Friday from 5:00 AM to 5:00 PM PST

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Section 4: Patient Referral information

Reason for referral: ☐ Addiction/SUD ☐ Mental Health ☐ Concurrent Mental Health + SUD ☐ Eating Disorder ☐ Trauma

Substance(s) of choice (if applicable): _____

Methadone: ☐ No ☐ Yes Dosage: mg/day Reason: _____
Suboxone: ☐ No ☐ Yes Dosage: mg/day Reason: _____

Has patient ever experienced severe withdrawal symptoms (DTs, psychosis, seizure, etc) ☐ No ☐ Yes:

To assist in a timely admission, if applicable, please provide the following information with your referral:
☐ Consent Form(s) ☐ Medication List ☐ Relevant Medical History:

☐ Previous Mental Health Hospitalizations/Inpatient Admissions:

Location	Date	Reason

If patient is being referred for Trauma Treatment, please indicate all types of trauma experienced:
☐ Violence/Sexual ☐ Accident ☐ Occupational ☐ Military ☐ Childhood

Section 5: Conditions/Diagnoses and Risks

Diagnosis	*Current Concern*	*Historical Concern*	Query
Acute or Chronic Psychosis	☐	☐	☐
ADHD	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐
Bipolar Disorder	☐	☐	☐
Borderline Personality Disorder	☐	☐	☐
Cognitive Disorder (other then Dementia)	☐	☐	☐
If yes, please describe: _____			
Dementia	☐	☐	☐
Dissociative Disorder	☐	☐	☐
Eating Disorder**	☐	☐	☐
PTSD - Trauma or OSI	☐	☐	☐
Major Depression	☐	☐	☐
Obsessive Compulsive Disorder	☐	☐	☐
Schizophrenia	☐	☐	☐
Substance Abuse (drug or alcohol)	☐	☐	☐

*** referrals for Eating Disorder will be required to complete a separate package, and submit recent lab work and ECG, prior to consideration.*

Current Safety Risks:

☐ Previous Suicidal Attempt: If applicable, date of last attempt: _____ Method: _____
☐ Active Suicidal Thoughts: If applicable, explain _____
☐ Self Harm If applicable, explain: _____
☐ Fire setting Behaviours If applicable, when: _____
☐ Violence towards others ☐ Wandering/AWOL risk ☐ History/risk of falling
☐ Patient is subject to a CTO ☐ Patient has a Substitute Decision Maker (SDM)
☐ Patient currently in hospital involuntary. Explain: _____
☐ Other: _____

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