HOME AND COMMUNITY CARE SUPPORT SERVICES
South East

MENTAL HEALTH & ADDICTION (MHAN) NURSE REFERRAL

PLEASE FAX TO : 1-613-650-2992

Student's Name ____________________

Gender: ☐ Male ☐ Female

Home Address ____________________

City ____________________ Postal Code ________

Phone ____________________ DOB ________ (DD / MM / YY)

HCN ____________________ VC ________
HCN entered by hospital or Home and Community Care Support Services South East Staff)

Parent/Guardian Contact Information

☐ Mother ☐ Father ☐ Guardian	☐ Mother ☐ Father ☐ Guardian
Name ____________________	Name ____________________
Home # ____________________	Home # ____________________
Cell # ____________________	Cell # ____________________
Bus # ____________________	Bus # ____________________
Address ____________________	Address ____________________
City ________ Postal Code ________	City ________ Postal Code ________

Languages Spoken in Home ☐ English ☐ French ☐ Other Specify ____________________

Interpreter Required ☐ No ☐ Yes Specify ____________________

Consent Information

Verbal/Written Consent for Referral Obtained from the Student ☐ No ☐ Yes Date ________ (DD / MM / YY)

Verbal/Written Consent for Referral Obtained from Parent/Guardian ☐ No ☐ Yes Date ________ (D D / MM / YY)

School Information

School Board ____________________

School Name ____________________ Grade ________

Reason For Referral

- ☐ Suicidal Ideation / Attempt / Risk to Self/others Specify ____________________
- ☐ Medical Concerns/Medication Management Specify ____________________
- ☐ System Navigation Specify ____________________
- ☐ Marked changed in presentation Specify ____________________
- ☐ Follow up with student from in-patient Specify ____________________
- ☐ clinical consultation with DSB staff Specify ____________________

MENTAL HEALTH & ADDICTION (MHAN) NURSE REFERRAL

Alcohol / Substance Misuse ☐ No ☐ Yes ☐ Suspected

Describe: ____________________

____

Please Include Additional Information and Summarize Reason for Referral:
(*i.e. Diagnosis, relevant information supporting reason for referral*)

____

____

____

____

____

____

____

____

____

____

____

____

Please attach supporting information with this referral:

Medical / Social Work / Psychiatric History ☐ Attached Medications *(please attach list)* ☐ Attached
Recent Laboratory Results *(within 3 months)* ☐ Attached D/C Summary ☐ Attached
Paraprofessional reports as relevant ☐ Attached

School Professional Services Staff Involved

____________________________________ (Name) ____________________________________(Contact)

____________________________________ (Name) ____________________________________(Contact)

____________________________________ (Name) ____________________________________(Contact)

Referral Source:

Name: ____________________________________ Title: ____________________________________

Phone # ____________________________________ Fax # ____________________________________

Signature ____________________________________ Date: ____________________________________

Date referral received by MHAN ____________________ Signature ____________________________