Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

MOCLI60149

Dossier : _____

Nom, prénom : [ ] _____

Date de naissance : _____ ☐ F ☐ M
aaaa/mm/jj

NAM : _____ Exp. _____
aaaa/mm

Nom, prénom de la mère : _____

Installation :

SERVICE REQUEST FOR VARIABLE-INTENSITY SUPPORT (VIS)

MENTAL HEALTH ACCESS MECHANISM			
☐ **Jardins-Roussillon**	☐ **Suroît**	☐ **Vaudreuil-Soulanges**	☐ **Haut St-Laurent (FACT)**
✆: 450-638-0894, ext. 7200 🖷: 450-638-8505 sante.mentale.1ereligne. cisssmo16@ssss.gouv.qc.ca	✆: 450-373-6252, ext. 5840 🖷: 450-373-0751 gasma.sr.cisssmo16 @ssss.gouv.qc.ca	✆: 450-455-6171, ext. 70305 🖷: 450-455-8162 gasma.vs.cisssmo16 @ssss.gouv.qc.ca	✆: 579-491-0148 🖷: 450-264-4542 sif.hsl.cisssmo16 @ssss.gouv.qc.ca
Referral date: _____ yyyy/mm/dd _____		Time: _____ hh:mm _____	

IDENTIFICATION OF SERVICE USER

Language(s) spoken: ☐ French ☐ English ☐ Other: _____

Details: _____

Address: _____

IDENTIFICATION OF REFERRING PERSON

Last name, first name: _____ Department: _____

Institution: _____ Occupation: _____

Telephone: _____ Fax: _____

PARTNER(S) INVOLVED

Last name, first name: _____ Occupation: _____ Phone: _____

Last name, first name: _____ Occupation: _____ Phone: _____

Last name, first name: _____ Occupation: _____ Phone: _____

RELEVANT INFORMATION

Primary, severe mental health diagnosis(es) made by a qualified professional: _____

_____

Associated diagnosis(es)/comorbidity(ies): _____

_____

Legal issue / dangerousness: _____

_____

Substance use / addiction / habits related to substance use: _____

_____

History of hospitalizations in the past two years / frequency of emergency visits: _____

_____

HISTORY OF MENTAL HEALTH AND/OR ADDICTION FOLLOW-UP
_____
_____
_____
_____

REHABILITATION NEEDS			
	YES	**NO**	Comment(s) (if yes, specify)
Uncooperative during medical appointments	☐	☐	
Medication non-adherence	☐	☐	
Housing instability	☐	☐	
Difficulty with activities of daily living and instrumental activities of daily living (ADLs and IADLs)	☐	☐	
Social disaffiliation	☐	☐	
Difficulty managing money	☐	☐	
Difficulty with work/time use	☐	☐	
Difficulty getting around (uses public transit, etc.)	☐	☐	
Difficulty using community resources	☐	☐	

Permanency plan, needs, or aspirations identified by the service user: _____

_____

_____

_____

Relevant information / recommendations: _____

_____

_____

_____

Referring person's signature and title: _____ Date: yyyy/mm/dd

☐ The service user consents to the service request for variable-intensity support (VIS) and to the opening of their file.
☐ The service user consents to the disclosure of information to the community and CISSSMO VIS programs for the purpose of reviewing the request.

Service user's signature: _____ Date: yyyy/mm/dd

☐ Provided verbal consent