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

MOCLI60367

Dossier : _____

Nom, Prénom : _____

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

NAM : _____ Exp. _____
aaaa-mm

Nom, Prénom de la mère : _____

Installation : _____

SERVICE REQUEST – YOUTH AND ADULT
REFERRAL TO THE CRD

SERVICE REQUEST :
☐ YOUTH *(age 17 and under) ☐ ADULT ☐ ENTOURAGE

PREFERRED LANGUAGE :
☐ FRENCH ☐ ENGLISH

☐ REFERRAL BYE THE DIRECTOR OF YOUTH PROTECTION (DYP), including the YOUTH CENTRES
Youth campus – UNIT *(where applicable)* : _____
Address : _____

IDENTIFICATION OF REFERRING PERSON

Last name : _____ First name : _____
Organization : ☐ Liaison : _____ ☐ Passerelle : _____ Phone : _____
Other professionals involved : _____ Availability for exchange : _____
(last name, first name)

SECTION RESERVED FOR HOSPITAL LIAISON AND « PASSERELLE » PROJECT

User coming from :
☐ 221 Physical emergency ☐ 224 Mental health care unit
☐ 222 Psychiatric emergency ☐ 225 Physical health car unit
☐ 223 Youth psychiatric emergency ☐ 226 Other hospital unit
Specify : _____

PATIENT IDENTIFICATION

Address : _____
City : _____ Postal code: _____
Email : _____
Phone no. - home : _____ Authorization to leave a message ☐ Yes ☐ No
Phone no. - work : _____ Authorization to leave a message ☐ Yes ☐ No
Cell. no. : Authorization to leave a message ☐ Yes ☐ No

ADDITIONAL INFORMATION ABOUT THE USER

Father's name : _____ _____
(last name) (first name)
Native language : _____ Place of birth : ☐ Québec ☐ Other Specify : _____

Emergency contact : _____ _____
(last name) (first name)
Email : _____ Relationship with user : _____
Phone no. : _____ Cell no. : _____

CIVIL STATUS

☐ Single ☐ Common-law ☐ Divorced ☐ Married
☐ Separated ☐ Widow·er ☐ Other : _____

Have you ever received services from the CRD of the CISSS de la Montérégie-Ouest (Virage or Foster) ? ☐ Yes ☐ No

Nom : Prénom : #Dossier :

OCCUPATION (adult section)

☐ Looking for a job	☐ Full-time studies/training	☐ Part-time studies/training
☐ Full-time work (35 + h/week)	☐ Part-time work (less than 35 h/week)	☐ Volunteering
☐ Sick leave, parental leave, strike	☐ Detained	☐ Homeless
☐ Seasonal worker on leave	☐ Disability / Inability to work	☐ Retired
☐ Homemaker	☐ Other : _____	

LIVING SITUATION

☐ Living with one or several relatives ☐ Leaving with one or several non-related persons *(foster home, youth centre, etc.)*

☐ Single-parent ☐ Couple with child·ren under 18 ☐ Couple without children ☐ Person living alone

REFERRED USER'S PROBLEM

☐ Alcohol ☐ Drugs ☐ Medications ☐ Gambling ☐ PIU

ASSOCIATED RISKS (attach to form)

☐ Suicide ☐ Homicide ☐ Aggression ☐ Disorganization ☐ Other : _____

SCREENING TOOLS (attach to form necessarily)

☐ DEP-ADO : ____ Score ☐ DÉBA-ALCOOL : ____ Score ☐ DÉBA-DROGUE : ____ Score ☐ DÉBA-JEU : ____ Score ☐ DÉBA-INTERNET : ____ Score

USER'S AVAILABILITY

☐ Morning ☐ Afternoon ☐ Evening

SECTION RESERVED FOR HOSPITAL LIAISON AND « PASSERELLE » PROJECT

DECISION FOLLOWING ANALYSIS

☐ Client abandons before analysis	☐ Accepted	☐ Ineligible (refused)
☐ Oriented towards : Other network mission	☐ Oriented towards : CH, CHSGS, CHPSY	☐ Oriented towards : Youth Centre
☐ Oriented towards CLSC	☐ Formal referral towards : volunteer, community or social economic resource	☐ Formal referral towards another CRD
☐ Formal referral towards a private or community resource	☐ Client's refusal	☐ Treated and completed

DISCLOSURE OF SUICIDAL AND HOMICIDAL RISK (if applicable)

☐ Services de réadaptation en dépendance	☐ Services ambulatoires de gestion de sevrage d'alcool	☐ Services de gestion de l'intoxication et du sevrage

COMMENT

AUTHORIZATION TO EXCHANGE INFORMATION (obligatory)

I authorize _____ to send this referral form, the completed screening tools, and all information related to the referral to the CISSS de la Montérégie-Ouest's Centre de réadaptation en dépendance (CRD). I authorize the referring healthcare professional to exchange information about this referral with the healthcare professional at the CISSS de la Montérégie-Ouest's Centre de réadaptation en dépendance (CRD).

THIS AUTHORIZATION IS VALID FOR 90 DAYS.

I understand that I may change or cancel this authorization at any time.

_____ _____
Signature of user or legal representative YYYY/MM/DD

_____ _____
Signature of referring healthcare professional YYYY/MM/DD

☐ Authorization received on : _____
YYYY/MM/DD

PLEASE SEND THE SIGNED FORM AND A COPY OF THE COMPLETED SCREENING TOOL (OBLIGATORY) TO THE CRD'S CENTRALIZED INTAKE DEPARTMENT OF THE CISSS DE LA MONTÉRÉGIE-OUEST

Montérégie (French – English)	**Montréal** (English)
Fax : **450 443-0522**	Fax : **514 486-2831**
Email : **accueil.dependance.cisssmo16@ssss.gouv.qc.ca**	Email : **accueil.montreal.dependance.cisssmo16@ssss.gouv.qc.ca**

FOR MORE INFORMATION, CALL THE CENTRALIZED INTAKE DEPARTMENT

Montérégie (French – English)		**Montréal** (English)	
Phone : **450 443-4413**	Toll-free : **1 866 964-4413**	Phone : **514 486-1304**	Toll-free : **1 866 851-2255**