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 ☐ Other

If Other - Identifies as: _____ Preferred Pronouns: _____

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

Name _____
Home # _____
Cell # _____
Bus # _____
Address _____
City _____ Postal Code _____

☐ Mother ☐ Father ☐ Guardian

Name _____
Home # _____
Cell # _____
Bus # _____
Address _____
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

☐ Clinical Consultation with DSB staff Specify

☐ Marked changed in presentation Specify

☐ Follow up with student from in-patient Specify

_____ Specify

System Navigation included, as needed,for those requiring other services as above

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 attached list)*	☐ Attached
Recent Laboratory Results	☐ 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** _____