SELKIRK MENTAL HEALTH CENTRE

REHABILITATION PROGRAM

REFERRAL FORM

I. PERSONAL DATA

Name: _____ ☐ Male ☐ Female

Home Address: _____ Telephone: _____

Current Address: _____

Date of Birth: _____ Marital Status: _____

MB Health #: _____ PHIN #: _____

Source of Income: _____ EIA #: _____

Legal Status: ☐ Voluntary ☐ Involuntary

☐ Form 9 If yes, treatment decisions by: _____

☐ Form 10 Name of Public Trustee (if any): _____

Order of Committeeship: If yes, date issued: _____

Person Responsible: _____

Next of Kin: _____ Relationship: _____

Address: _____ Telephone (home): _____

_____ Telephone (bus.): _____

Previous admission(s) to Selkirk Mental Health Centre? ☐ Yes ☐ No

II. PSYCHIATRIC DATA

Psychiatric Diagnosis: _____

Onset: _____ Admissions: _____

Previous involvement in any rehab program? _____

Current level of motivation/readiness for a rehab program: *(please check one)*

☐ Motivated to working on recovery ☐ Uncertain at this time ☐ Does not wish to participate

Current Medications and Treatments *(include name, dosage and compliance)*:

Past Medications Attempted Over Last 5 Years:

Treating Psychiatrist: _____ Telephone: _____

Address: _____

Current Level of Functioning:

Behaviour: _____

Personal Care: _____

Mobility: _____

Strengths: _____

Interests: _____

History of Aggression/Current Aggression: _____

Current Legal Issues: _____

Alcohol/Substance Abuse: _____

Suicidal Ideation: _____

Family Involvement with Client/Patient: _____

CMHW or Other Agencies Involved: _____

Number and List all Placements Tried: _____

Support System Professional Supports: _____

Personal Supports: _____

Current Residence/Placement: _____

III. MEDICAL DATA *(significant medical history such as allergies, seizures, disabilities, diet, etc.)*

_____

Has the person received the COVID-19 Vaccine? ☐ No ☐ Yes _____ Date

Does the person use a CPAP machine? ☐ No ☐ Yes

Physician: _____ Telephone: _____

Address: _____

V. REFERRAL SOURCE

Name: _____ Position: _____

Address: _____ Telephone: _____
Street

_____ Fax: _____
Box # RR#

_____ Email: _____
City

_____
Postal Code

Primary Contact Name: _____ Telephone: _____

Reason for Referral: _____

_____

_____

_____

What SMHC services do you feel are required for this client? _____

_____

_____

_____

Community plan following discharge from Selkirk Mental Health Centre (ex: maintain contact with PACT):

_____

_____

_____

Is the client/patient agreeable to SMHC admission? ☐ Yes ☐ No

Is the family agreeable to SMHC admission? ☐ Yes ☐ No

Date referring facility met with family to discuss SMHC admission: _____

Does client/patient wish to tour the identified program at SMHC? ☐ Yes ☐ No

Does the family wish to tour the identified program at SMHC? ☐ Yes ☐ No

Please ensure the following are attached in order to assist the review teams with making a decision regarding the referral:

1. Significant medical/psychiatric reports
2. Detailed social history
3. Psychological assessment
4. Occupational therapy assessment

_____ _____

Signature of referring source Date

Please complete and forward to the Bed Utilization Manager via fax to 204-785-1507.
Forward original in mail to:

Bed Utilization Manager
Rehabilitation Program
Selkirk Mental Health Centre
Box 9600, 825 Manitoba Avenue
SELKIRK MB R1A 2B5