



# Referral Form

If you have any questions about the referral process, please call:

**South Coast Wellness at  
1-877-909-4357**

## INFORMATION FOR REFERRING PROVIDERS:

- **Psychiatry (16+):** A physician or nurse practitioner must complete referrals to psychiatry. Psychiatrists provide consultation for diagnostic clarification and treatment recommendations.
- **Psychotherapy & Addiction Counselling:** Services involve structured treatment and are goal oriented and time limited. Self-referrals accepted. Clients aged 16+ are contacted directly unless consent to contact a caregiver is provided. Clients may also self refer on our website.
- **Geriatric Services:** Physicians in the ER, Long Term Care and local hospitals please complete this referral form if requesting specialist consultation. Clients living in the community, which includes retirement homes, family physicians complete the Central Clinical Intake Referral form with the Regional Geriatric Program (RGP). All providers can use this referral form to refer to Intensive Geriatric Service Worker (IGSW).
- **Addiction Mobile Outreach Team (AMOT):** Service supports individuals with an identified addiction concern through engagement, prevention, education and short-term treatment in the community.
- **Resources for HOPE:** Supportive programming, psychosocial groups, wellness and recreational programming. This is not a counselling/therapy service.
- **Peer Support:** Supportive coaching and general support. This is not a counselling/therapy service. Peer support for substance use and recovery is also available.

## INFORMATION FOR YOUR CLIENT:

- All services are voluntary: Please ensure your client/representative is aware that you are making this referral
- South Coast Wellness makes several attempts to contact a client, when consent is provided. If the client can not be reached, the referring provider will be notified
- Clients may be placed on a wait list for service
- Please refer clients to our 24-hour Crisis Assessment and Support Team (CAST) at 1-866-487-2278 should crisis support be required

## HOW TO SUBMIT A REFERRAL:

- Please fax the completed referral form to 519-426-3257 (alternatively, primary care providers have the option to complete e-referrals on OCEAN and/or EMHware)
- Please ensure each referral is faxed individually
- To help us provide the best care possible, include relevant documents, such as previous psychiatric consultations or discharge summaries, medication sheets, psychological reports, lab and test results, medical reports and physical findings
- Referrals received with insufficient information will be returned and placed on hold until the information requested is received

**If your client is in immediate crisis and is an acute risk to themselves and/or others, please call 911 and/or direct your client to the nearest emergency department**



**South Coast Wellness**  
Addiction and Mental Health

## Referral Form

Clients can self-refer by going to  
[www.southcoastwellness.org](http://www.southcoastwellness.org)

CLIENT INFORMATION	
<b>Legal Name</b>	
First Name: _____ Last Name: _____	<b>Preferred Name</b> (if applicable) _____
<b>Date of Birth</b> (DD/MM/YYYY): _____	<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Woman <input type="checkbox"/> Trans Man <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Genderqueer <input type="checkbox"/> Gender fluid <input type="checkbox"/> Androgynous <input type="checkbox"/> Non-binary <input type="checkbox"/> Other: _____
<b>Patient Address:</b>	
Address: _____	Unit # _____
City: _____	Province: _____ Postal Code: _____
<b>Health Card Information:</b>	
Health Card #: _____	Version Code: _____ Expiry Date: _____
<b>Is there a need for an interpreter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify what language _____ <b>Are there any accessibility concerns?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify _____ <b>Does the client identify as Indigenous or another racialized group?</b> If yes, please specify _____	

CLIENT or DELEGATE CONTACT INFORMATION (for individuals under 16 and Geriatric referrals)	
By listing telephone numbers or an email address below, the referral source confirms that the patient consents for South Coast Wellness to communicate with them via telephone and/or email regarding this referral. South Coast Wellness will refrain from communicating unrequired personal health information until consents are verified. Contact information below is for: <input type="checkbox"/> <b>Client</b> <input type="checkbox"/> <b>Delegate</b> (for individuals under 16 and Geriatric referrals)	
<b>If Delegate, please specify:</b>	<b>Relationship to Individual:</b>
First Name: _____ Last Name: _____	_____
Address: _____	_____
Phone Number: _____	E-Mail Address: _____
Permission to Contact by: <input type="checkbox"/> Phone <input type="checkbox"/> Permission to leave voicemail <input type="checkbox"/> Text <input type="checkbox"/> E-mail <input type="checkbox"/> Mail	
<b>REASON FOR REFERRAL</b> (Please indicate the primary reason for referral (current symptoms, presenting problems, and history))	



SAFETY CONCERNS			
Risk	Within past 3 Months	More than 3 Months Ago	Details
Suicide Attempt			
Suicidal Ideation			
Deliberate Self-Harm			
Homicidal Threats/Ideation			
Aggressive Behaviour			
Other:			

SERVICE(S) REQUESTED		
<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Addictions	<input type="checkbox"/> Geriatric Specialist Consultation
<input type="checkbox"/> Psychotherapy	<input type="checkbox"/> Resources for HOPE	<input type="checkbox"/> Intensive Geriatric Service Worker
<input type="checkbox"/> Peer Support		

CURRENT MEDICATIONS and MEDICAL/DEVELOPMENTAL/TREATMENT HISTORY (please include assessments, discharge summaries, progress notes from other agencies, hospitals or therapies within last 1 year)
<b>Diagnoses Confirmed by Psychiatrist:</b> <input type="checkbox"/>

REFERRING PROVIDER INFORMATION		
Name of Provider:		Signature ( <b>required</b> ):
Billing #:	Telephone #:	Fax #:
CLIENT SIGNATURE (Required if Self-Referring):		
Client Signature: _____		Date Signed: _____

**\*FAILURE TO PROVIDE ADEQUATE INFORMATION DOES DELAY THE REFERRAL PROCESS\***

Please Note: Submission of this referral does not constitute automatic acceptance into treatment or services. A clinical assessment will be conducted, and services will be provided based on eligibility, availability, and clinical appropriateness. We cannot assume any medical or legal responsibility for a client's healthcare while they are awaiting services.