Recovery Alberta
MENTAL HEALTH AND ADDICTION SERVICES

Intensive Outreach & Diversion Services
631 Prospect Dr. SW, Medicine Hat, AB T1A 4C2
PH: 403.502.8617 Fax: 403.502.8618

Complete all fields. Incomplete referrals will not be processed and returned for completion.

Physician Referral Only

- ☐ Outreach Addictions Counselor
- ☐ Community Support Program (CSP)
- ☐ Harm Reduction Intervention Services
- ☐ Nurse Practitioner
- ☐ Recreation Therapy
- ☐ Seniors Addiction & Mental Health Therapy
- ☐ Depot Clinic

May use patient label

Client Name:	Date Referral Completed: *(yyyy-Mon-dd)*
DOB: *(yyyy-Mon-dd)*	Referral Source:
PHN/ULI:	Referral Source Phone Number:
Address:	Guardian/Substitute Decision Maker ☐ Yes ☐ No
Postal Code:	Guardian/SDM Name:
Primary Phone:	Guardian/SDM Phone Number:
Preferred Pronoun:	Emergency Contact Name:
Current Housing Status:	Emergency Contact Phone Number:
Client admitted to hospital ☐ Yes ☐ No Site/Unit:	Income Source: AISH/Income Support ☐ Yes ☐ No
Addiction/Mental Health/Medical History	
Psychiatrist:	Physician:
Addiction/Mental Health Diagnosis:	
Medical Condition(s):	
Substance Use History:	
Medications	
Write or attach medication list:	
Does client have medication coverage? ☐ Yes ☐ No	

Risk Factors/History		
Self Harm/Suicide:	Aggression/Violence:	Legal/Other:
Self Harm ☐ Yes ☐ No	Verbal ☐ Yes ☐ No	
Suicidal Ideation ☐ Yes ☐ No	Physical ☐ Yes ☐ No	
Suicide Attempt ☐ Yes ☐ No	Sexually ☐ Yes ☐ No	

Is client aware of referral? ☐ Yes ☐ No Does client agree with referral? ☐ Yes ☐ No

Clients' Needs/ Reason for Referral (*must complete)	FOR OFFICE USE ONLY
	Date Referral Received_____
	Referral Complete/Incomplete_____
	Date Returned to Referral Source_____
	Date Transferred to Central Access_____
	Referral forwarded to_____