Self-Referral for Mental Health and Substance Use Services – Gabriola Outreach

Please take a moment and complete the following information:

Date _____

Name _____

Street Address _____

Mailing Address (if different) _____

City _____ Postal Code _____

Home Phone _____ Cell Phone _____

Email Address _____

Birth Date (dd-mm-yyyy) _____ Care Card # _____

Family Physician _____ Psychiatrist _____

Emergency Contact - Name _____ Relationship _____

Emergency Contact - Home Phone _____ Cell Phone _____

EMPLOYMENT STATUS

- ☐ Full Time
- ☐ Part Time
- ☐ Not Employed
- ☐ Student
- ☐ Not Applicable

MARITAL STATUS

- ☐ Married/CPL
- ☐ Separated
- ☐ Divorced
- ☐ Single
- ☐ Window/er

LIVING SITUATION

- ☐ Living Alone
- ☐ Family
- ☐ Group Home
- ☐ Institution
- ☐ Roommate
- ☐ Other

MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ALCOHOL USE PROBLEM?

- ☐ Yes
- ☐ No
- ☐ History
- ☐ Unsure

DRUG USE PROBLEM?

- ☐ Yes
- ☐ No
- ☐ History
- ☐ Unsure

ABUSE HISTORY?

- ☐ Yes
- ☐ No
- ☐ History
- ☐ Unsure

HEAD INJURY?

- ☐ Yes
- ☐ No
- ☐ Unsure

LEGAL CONFLICT?

- ☐ Yes
- ☐ No
- ☐ Unsure

1. With whom do you wish to speak?

- ☐ Mental Health and Substance Use Nurse
- ☐ Mental Health and Substance Use Social Worker

2. What concerns do you wish to speak to a clinician about?

_____

_____

3. Have you previously been connected with Mental Health and Substance Use services?

☐ Yes ☐ No

If yes, what services did you access?

_____

~ Please return this form to Gabriola Medical Clinic (for faxing to 250-755-3310) ~