# AGENCY REFERRAL FORM
# STABILIZATION UNIT

**Date:**

**Client Name:**

**Address:**

**Contact #:**

**HSN#:**

**Treaty # & Band:**

**Date of Birth:**

**Medical Information:** ***(Attach Medical)***

**Medical Concerns:**

**Mental Health Concerns:** **No referral accepted for clients who have attempted suicide within 6 months**

***(Attach Suicide Risk Scale):***

**Legal:** **(*attach Probation Order*)**

**Community Case Manager/Agency & Contact #:**

**Admission Date:** ***(Detox)*** **Discharge Date:**

**Case Disposition:**

**Summary :( include Presenting Problem/Drug of Choice, last date used and amount, behaviors etc.)**

**Action Plan: (include Primary Assessment for Inpatient Treatment)**

**Completed by:**