



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: