

Alert Date: (dd/mm/yy)	Time:	FYI
	am	Telephone Contact
	pm	Mobile Visit Requested

Is the Client aware of this referral? **Yes** **No**

Client Surname:	DOB (dd/mm/yy):	Gender
Given Name:		M F
Street Address:	City:	PC:
Telephone #:	Alias(es):	
G.P. Name:	G.P. Phone #:	
Psychiatrist Name:	Psychiatrist Phone#:	
Next of Kin:	Next of Kin Phone #:	
Number of Emergency Room visits in past 1 year:	Nature of hospitalizations (i.e. substance use/mental health related):	
Diagnosis:	Last Hospitalization:	
	Where hospitalized:	
History of Substance Abuse: Yes No Details:		
Currently Suicidal: Yes No	Currently Violent: Yes No	
Details:	Trigger:	
	Details:	
Date and details of previous suicide attempts:	Date and details of previous violence:	
Presenting Problems/Concerns (include hallucinations, delusions, paranoia etc.)		
Physical Disabilities:	Allergies:	
Current Medications:		
Physical Description:		
Additional Information: (Ex. Other services involved, criminal justice involvement, etc.)		
Person/Agency Issuing Alert:		
Phone Number:	Fax Number:	

~Please Call to Ensure Fax is Received~