Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

Facility: _____

File: _____

Last name, first name: _____

Date of birth: _____ ☐ F ☐ M
yyyy-mm-dd

RAMQ no.: _____ Exp. _____
yyyy-mm

Mother's name: _____

SERVICE REQUEST – YOUTH AND ADULT REFERRAL TO THE CRD

SERVICE REQUEST:
☐ YOUTH* (age 17 and under) ☐ ADULT

PREFERRED LANGUAGE:
☐ FRENCH ☐ ENGLISH

☐ REFERRAL BY THE DIRECTOR OF YOUTH PROTECTION (DYP), including the YOUTH CENTRES
Youth campus – UNIT *(where applicable)*: _____
Address: _____

IDENTIFICATION OF REFERRING PERSON

Last name: _____ First name: _____
Organization: _____ Phone: _____
Other professionals involved: _____ _____
COMMENT: (Last name) (First name)

PATIENT IDENTIFICATION

Address: _____
City: _____ Postal code: _____
Email: _____

Phone no. - home:	_____	☐ Authorization to leave a message	☐ Yes	☐ No
Phone no. - work:	_____	☐ Authorization to leave a message	☐ Yes	☐ No
Phone no. - other:	_____	☐ Authorization to leave a message	☐ Yes	☐ No
Cell no.:	_____	☐ Authorization to leave a message	☐ Yes	☐ No

ADDITIONAL INFORMATION ABOUT THE USER

Father's name : _____ _____
(Last name) (First name)
Native language: _____ Place of birth: ☐ Québec
☐ Other Specify: _____

OCCUPATION (adult section)

☐ Looking for a job	☐ Full-time studies/training	☐ Part-time studies/training
☐ Full-time work (35+ h/week)	☐ Part-time work (< 35 h/week)	☐ Volunteering
☐ Sick leave, parental leave, strike	☐ Detained	☐ Homeless
☐ Seasonal worker on leave	☐ Disability/Inability to work	☐ Retired
☐ Homemaker	☐ Other: _____	

LIVING SITUATION

☐ Living with one or several relatives	☐ Living with one or several non-related persons *(foster home, youth centre, etc.)*	
☐ Single-parent		
☐ Couple with child(ren) under 18	☐ Couple without children	☐ Person living alone

Last name: File no.:

CIVIL STATUS			
☐ Single	☐ Common-law	☐ Divorced	☐ Married
☐ Separated	☐ Widow(er)	☐ Other: _____	

Have you ever received services from the CRD of the CISSSMO (Virage or Foster)
☐ Yes → Write the name of the point of service _____
☐ No

Emergency contact: _____ (Last name) _____ (First name)
Email: _____ Relationship with user: _____
Phone no.: _____ Cell no.: _____

REFERRED USER'S PROBLEM

☐ Alcohol ☐ Drugs ☐ Medications ☐ Gambling ☐ Cyber-dependence ☐ Entourage

SCREENING TOOLS (attach to form)

☐ DEP-ADO	☐ DÉBA Alcool	☐ DÉBA Drogue	☐ DÉBA Jeu
_____ Score	_____ Score	_____ Score	_____ Score

USER'S AVAILABILITY

☐ Morning ☐ Afternoon ☐ Evening

COMMENT:

AUTHORIZATION TO EXCHANGE INFORMATION

I authorize _____ to send this referral form, the completed screening tools, and all information related to the referral to the CISSS de la Montérégie-Ouest's Centre de réadaptation en dépendance (CRD).

I authorize the referring healthcare professional to exchange information about this referral with the healthcare professional at the CISSS de la Montérégie-Ouest's Centre de réadaptation en dépendance (CRD).

THIS AUTHORIZATION IS VALID FOR 90 DAYS

I understand that I may change or cancel this authorization at any time.

_____ _____
Signature of user or legal representative yyyy-mm-dd

_____ _____
Signature of referring healthcare professional yyyy-mm-dd

PLEASE SEND THE SIGNED FORM AND A COPY OF THE COMPLETED SCREENING TOOL TO THE CENTRALIZED INTAKE DEPARTMENT OF THE CISSS DE LA MONTÉRÉGIE-OUEST'S CRD

Montérégie (French – English)	**Montréal** (English)
Fax: **450-443-0522**	Fax: **514-486-2831**
Email: **accueil.dependances.cisssmo16@ssss.gouv.qc.ca**	Email: **accueil.montreal.dependance.cisssmo16@ssss.gouv.qc.ca**

FOR MORE INFORMATION, CALL THE CENTRALIZED INTAKE DEPARTMENT

Montérégie (French – English)	**Montréal** (English)
Phone: **450-443-4413** Toll-free: **1-866-964-4413**	Phone: **514-486-1304** Toll-free: **1 866 851-2255**