ROUGE VALLEY HEALTH SYSTEM: SHONIKER CLINIC

FIRST INTERVENTION TREATMENT TEAM (F.I.T.T.)

REFERRAL FORM

Please Fax Referrals to F.I.T.T Intake: 416-281-7465

Name:	Referral Date:
Sex:	Chart #:
D.O.B.: Age:	Referral Source:
H.C.#	Phone:
Address:	
Apt: City:	Contact:
Postal Code:	Relationship to Client:
Phone: (H)	Phone #:
(Other)	
Language(s) Spoken:	
PRESENTING PROBLEM	
Describe symptoms:	
PSYCHIATRIC AND MEDICAL INFORMATION	
Diagnosis:	
Psychiatrist Name:	Phone:
Family Doctor Name:	Phone:
Allergies:	If Yes Describe:
Medical Conditions:	
Medications:	
Past / Present side effects experienced:	

DETAILED TREATMENT HISTORY

Start Date	End Date	Agencies/Services Involved	Outcome

CHECK ALL THAT APPLY

	Yes	No	Current or Past	Circumstances, Frequency, Severity
Suicidal Ideation				
Harm to Self or Others				
Homicidal Ideation				
Legal History				
Drug/Alcohol Abuse				
Other Relevant Information				

SUPPORT INFORMATION

Formal Supports (Physician, Social Worker, etc.):

Informal Supports (Family, Friends, etc.):

Current Living Arrangements:

Income Source:

Education Completed: Name of School:

Employment History / Volunteer History:

Other Training / Skills:

Current Daytime Activity:

GOALS FOR ADMISSION

Please attach any reports, consultations etc. and return to the F.I.T.T.