

HomeBase Referral Form

Referring Agency: _____

Date: _____

Contact Person: _____

Phone: _____



Person Referred: _____

Age: _____

Sex: _____

Client of CAMHC? **Y / N**

Does this person have a mental illness diagnosis other than substance abuse? **Y / N**

Does this person have a history of substance abuse? **Y / N**

If yes, when is this person last known to have used alcohol or drugs? _____

Does this person have any physical disabilities or medical conditions that significantly affect his or her functioning? _____

Is this person generally cooperative with treatment providers? _____

Current living situation: _____

Sources of income (if any): _____

Services likely to be needed to support residential stability: _____

How can this person be contacted? _____

