St. Leonard's COMMUNITY SERVICES
Challenge. Choices. Change.

RESIDENTIAL and DAY TREATMENT REFERRAL COVER SHEET

REFERRAL DATE: / / **DAY TREATMENT** ☐ **RESIDENTIAL TREATMENT** ☐
DD MM YYYY

REFERRING PARTY INFORMATION			
Agency Name			
Staff Name			
Staff Phone #		**Staff E-mail**	

CLIENT INFORMATION	
Client Name	
Client DOB	
Client Phone #	
	Client permission to call? ☐Yes ☐No Text? ☐Yes ☐No Can we leave a message? ☐Yes ☐No
Client E-mail	
Client Address	
Client Gender	

ASSESSMENT INFORMATION
NOTE: Standardized assessment (GAIN Q3 MI ONT or ADAT) is required.

GAIN Q3 MI ONT completed? ☐Yes ☐No (Edited/final Recommendation & Referral Summary and Diagnostic Impressions Report must be attached)

ADAT completed? ☐Yes ☐No (ADAT Tracking Summary, DHQ and Health Screening Form must be attached)

Have there been any significant changes in the client's substance use pattern, health status or living situation since the assessment was completed? ☐Yes ☐No

If yes, please describe:_____
_____
_____
_____
_____
_____

ADDITIONAL RELEVANT INFORMATION	REFERRAL CHECKLIST
	☐ Consent to release/obtain info complete & attached ☐ Referral cover sheet completed ☐ Assessment complete & attached

REFERRAL FAX #: 226-250-1043