Gerstein Crisis Centre

Gerstein on Bloor - Crisis Beds for Women
Dealing with Mental Health and Homelessness

Referral Form

Gerstein on Bloor Phone # - (416) 604-2337(BEDS)
Fax # - (416) 604-7436
E-mail: gersteinonbloor@gersteincentre.org

To provide short-term crisis beds for women who are experiencing a mental health crisis and are currently experiencing homelessness.

Basic Eligibility Criteria

- **Women 16 years+**
- **Experiencing a mental health crisis**
- **Currently homeless**
- **Safely supported in the community**

Staff Making Referral

Name: _____

Agency: _____

Sector_____

Phone #: _____

Fax #: _____

Release of information for the purposes of this referral have been agreed to by the client

Yes ☐ No ☐

Person in Crisis

Name: _____

D.O. B.: Day _____ Month _____ Year _____

Female ☐ Preferred Identity _____

Current Location: _____

Address: _____

Phone #: _____

Housing/Living Situation: _____

Income Source: _____

Identification: Yes ☐ No ☐

Drug Card: Yes ☐ No ☐

O.H.I.P. #: _____ _____

SIN # _____

Preferred Language: _____

Presenting Problem / Current Crisis / Reason for Referral

Y/N	Presenting Issue	Description/Details
	Threat to others/attempted suicide	
	Specific symptoms of SMI (serious mental illness)	
	Physical/sexual abuse	
	Educational	
	Occupational/employment /vocational	
	Housing	
	Financial	
	Legal	
	Problems with relationships	
	Substance abuse	
	Activities of Daily Living (A.D.L.)	
	Other	

Supports		
Relationship	Name/Agency	Phone #
G.P.		
Psychiatrist		
Therapist		
Case Manager		
Probation/Bail Officer		
Lawyer		
Court Support		
G.P.		
Family/Friend		
Other		

Safety Risks				
Y/N	Risks	Current	History	Description /Details / Dates
	Suicide			
	Violence			
	Substance Use			
	Self Harm			
	Verbal Aggression			
	Weapons			
	Arson			
	Sexual Assault			

Current prescribed medications (please include all medications)		
Medication	Dose	Frequency

Does client have a prescription and/or medication? Yes ☐ No ☐

Describe: _____

History of Hospitalization for Mental Heath reasons: Yes ☐ No ☐

Most recent hospitalizations			
Date	Hospital	Length of stay	Reason

Mental Health Diagnosis: Yes ☐ No ☐ _____

Follow-up? Yes ☐ No ☐

By whom? Name: _____ Phone #: _____

Where: _____ When: _____

Physical Health Concerns/Special Needs
(dietary, mobility/accessibility, physical care, dual diagnosis, chronic condition, etc.)

Allergies:

Housing: History in the last 12 months

Housing: CASH application on File? Yes ☐ No ☐

If yes file # _____