PRIMARY SUPPORT UNIT
CLIENT REFERRAL APPLICATION

To: Primary Support Unit **DATE:**

The Salvation Army Maxwell Meighen Centre

Counselling Services (FAX):(416) 366-4229

CONTACT			
FROM			
ADDRESS			
PHONE		**FAX**	
CLIENT		**D.O.B (D/M/Y)**	
HEALTH CARD#		**S.I.N.**	
ATTENDING PHYSICIAN OR WORKER		**PHONE#**	

PRESENTING PROBLEM/REASON FOR REFERRAL

What expectation do you have of the P.S.U?

What will be the continuing role of the referral source?

Medication Schedule

Type		Dosage	
Type		Dosage	
Type		Dosage	
Type		Dosage	
Type		Dosage	
Type		Dosage	

Client Support Network

Psychiatrist's Name		Tel:	
Family Doctor's Name		Tel:	
Mental Health Workers		Tel:	
Housing Workers		Tel:	

Are there any other agency contacts presently working with client? YES ☐ NO ☐

If yes, please provide name and telephone numbers:

Name		Tel:	
Name		Tel:	

Does the client have any issues/concerns with any of the following?

Physical Health ☐ Substance Abuse ☐ Self-Harm ☐ Suicide Attempts ☐
Mental Health ☐ Suicide Ideations ☐ Mobility ☐ Special Diet ☐

Please explain:

Are there any pre-arranged appointments?

Date/Time		**Location**		**With Whom**	
Date/Time		**Location**		**With Whom**	

Other information:

Signature of Worker: _____