l'éveil Ressource communautaire en santé mentale

Referral Form

Contact information

First name: Last name:

Address:

Phone no.: Age: Date of birth:

Self-esteem self-management	☐	Group art therapy	☐
Depression self-management	☐	Living environment	☐
Anxiety self-management	☐	Creation workshop	☐
Personal growth workshop	☐	Individual service	☐
Other:	☐	Service for 12-18-year-olds	☐

Reason for the referral and formulation of the person's request:

Additional information:

1. Diagnosis (or diagnoses):

2. Symptoms:

3. Current psychosocial context (housing, studies or work, income, marital status, children, etc.). Stability?

4. Predisposing factors (heredity, family environment, role reversal in childhood, temperament, abuse, neglect, overprotection, etc.):

5. Impact of the problem on the person's life (interpersonal, professional, personal):

AUTHORIZATION TO TRANSMIT THIS FORM AND TO COMMUNICATE INFORMATION RELEVANT TO THE ANXIETY MANAGEMENT PROGRAM BETWEEN THE REFERRING ORGANIZATION AND A MEMBER OF THE ORGANIZATION L'ÉVEIL, RESSOURCE COMMUNAUTAIRE EN SANTÉ MENTALE, FOR A PERIOD OF ____DAYS.

_____ Date

_____ Signature of the user or respondent

_____ Date

_____ Signature of the referring professional

_____ Referring organization

Please note that this questionnaire is in no way mandatory for referring someone to L'Éveil services. Rather, it is intended as an additional tool. Professionals can continue to call or send an email, or the person can contact a counsellor themselves. In addition, the authorization to disclose information may be revoked by the member at any time.