

**ADDICTION CENTRE ADOLESCENT PROGRAM
REFERRAL INFORMATION**

Our mandate is the assessment and treatment of adolescents (age 13-17) with chemical dependency issues and/or behavioural addiction combined with severe persistent emotional, behavioural or psychiatric concerns.

Patient Name: _____ Gender: ____ Birth Date: _____
AHC#: _____ Address: _____
City _____ Province _____ Postal Code _____
Parent/ Guardians: _____
(Names) (Phone Numbers)
Family Physician: _____ Address: _____
Phone Number: _____

***NOTE: All patients referred to the Addiction Centre must have written referral/approval from the family physician in order for an assessment to be arranged.**

Referral Source (if different from family physician): _____
Address: _____ Phone Number: _____

Mental Health Problems/Working Diagnosis:

Mental Health History:

Mental Health Treatment:

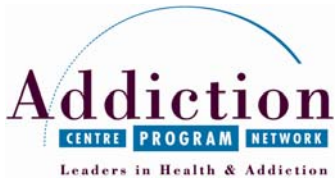
Hospitalization:

Is the client currently hospitalized: __ Yes __ No If yes, where: _____

Suicide History:

Actively Suicidal: __ Yes __ No
Previous Attempts: __ Yes __ No

Please fax (944-2056) or send original by mail to:
Addiction Centre, Foothills Medical Centre, 1403-29 Street NW Calgary AB T2N 2T9
We will contact the patient directly for an appointment. If you have any questions with regards to this referral, call 944-2025 and ask to talk to the intake worker.



Please provide brief details regarding suicide:

Brief Medical History/Current Concerns:

Current Medications: _____

Allergies: _____

Current Substance Use/Behavioural Addiction	Duration
_____	_____
_____	_____
_____	_____

Past and Current Substance Use Treatment:

Past/Current Legal Concerns:

Risk Factors: Violence Abuse (Circle: Emotional / Physical/ Sexual)

Provide Details: _____

Support System for parents/ guardian (E.g. Child & Family Services, Alberta Mental Health Services) _____

Are parents/ guardians aware of referral and in agreement with referral? (Yes/ No)

Additional Comments: _____

Signed: _____ **Date:** _____

(Please include any relevant patient documents)

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