CASS

Creative Community Living Activities Referral Form

Name: ______________________________

Address ______________________________

City/Province
Postal Code ______________________________

Referral Date: ______________________________
(YYYY-MM-DD)

Phone: ______________________________

Date of Birth: ______________________________
(YYYY-MM-DD)

Provincial Health Care Number: _______________

Referral Source (name): ______________________________

Responsible Physician: ______________________________ Phone: ______________________________

Follow-up Worker: ______________________________ Phone: ______________________________

Other Agencies Involved:

Present Medication(s):

Please check appropriate group(s) for client:

Seniors Group: ☐ Leisure Group: ☐ Wellness Group: ☐

Coffee Group: ☐ Craft Group: ☐ ☐

Reason for Referral:

Diagnosis (Axis 1 and Axis 2):

Creative
Community
Living
Activities
CCLA

240, 815 8th Avenue SW | Calgary AB | T2P 3P2
www.c-a-s-s.org | P: 403.264.1377 | F: 403.264.1377

Brief Description of Psychiatric History and Problems (copy of recent history would be appreciated):

Concerns Regarding:

Suicide Risk: ☐ Motivation: ☐ Aggression: ☐ Attendance: ☐ Transportation: ☐

Substance Abuse: ☐ Accommodation: ☐ Other: ______________________

Specify in Detail Any Additional Information:

Goals To Be Worked On In Program:

1: ______________________

2: ______________________

3: ______________________

Current Interests In Leisure Activities:

Additional Information pertinent to establish and co-ordinate applicant's course of treatment while at CCLA:

Please submit completed referral forms via email to ccla.intake@c-a-s-s.org or via fax to 403.264.1377

______________________ ______________________

Signature of Referral Source Signature of Client

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