Karis Support Society
1849 Ethel St. Kelowna B.C. V1Y 2Z2
Tel: 250.860.9507 Fax: 250.860.9517
www.karis-society.org

KARIS VILLAGE REFERRAL FORM

960 Graham Rd, Kelowna, B.C. V1X 1J4
Tel: 778.478.2239 Fax: 778.478.4239

Referral Information: DATE: _____

Referring Agent: _____ Email: _____

Agency Name: _____ Address: _____

Agency Phone: _____ Agency Fax: _____

RESIDENT Information:

First Name: _____ Middle Name: _____Last Name: _____

Address: _____ City: _____ Postal Code: _____

Telephone #: _____Alternative #: _____

Care Card No: _____ DOB: _____ SIN: _____

Marital Status: _____ Pregnant_____ Due date_____

Number of Children: _____ Number of dependent children: _____

Names and Ages of Children: _____

_____

Where do children reside: _____

_____

Emergency Contact Info:

Name: _____ Address: _____

Telephone: _____ Alternative #: _____

Relationship: _____

Family Physician: _____ Telephone: _____

Psychiatrist: _____ Telephone: _____

Dentist: _____ Telephone: _____

Paediatrician: _____ Telephone: _____

Emergency Contact Info Cont:

Alcohol & Drug Counsellor: _____ Telephone: _____

Mental Health Worker: _____ Telephone: _____

Social Worker: _____ Telephone:_____

Other Professional/Community Supports: _____

Medical Conditions: _____

_____

Allergies: _____

Head injury/concussion: Y/N_____ Describe:_____

_____

Family history with alcohol, any possibility of Fetal Alcohol Effects/Syndrome: Y/N _____

Describe:_____

Mental Health Diagnosis:

_____

_____

Medications/Date started: (Include dosage)

_____
_____
_____
_____
_____
_____

Condition(s) Being Treated:

_____
_____
_____
_____
_____
_____

Are any of the following health risk behaviours currently present? (Within the last 6 months.)

			How often	last time	Management
Seizures	Yes ___	No ___	_____	_____	_____
Suicide attempts	Yes ___	No ___	_____	_____	_____
Self-inflicted violence (e.g. Cutting)	Yes ___	No ___	_____	_____	_____
Hospitalization for Psychiatric illness	Yes ___	No ___	_____	_____	_____

Does resident have a history of: physical and/or sexual abuse? _____

ALCOHOL & DRUG USE SUMMMARY:

Substance Used	**Years of use**	**Date of last use**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Other addictions of concern (e.g. gambling, shopping):_____

_____

Experience with:	**Dates or No of times**	**Complete**	**Incomplete**
Residential treatment	_____	_____	_____
Supportive Recovery	_____	_____	_____
Detox	_____	_____	_____

Does resident have pending charges, court involvement or probation/bail commitments?

No _____ Yes _____ **Please describe:** _____

_____

_____

Education: _____

Does resident have any special needs (i.e. literacy, disability)? Yes _____ No _____

Please describe:_____

_____

Income: Income Assistance: _____Disability: _____

Other: _____Receiving Prenatal Allowance:_____

Additional Notes:_____

_____

_____