550 Rowcliffe Ave.
Kelowna, BC V1Y 5Y9
info@karis-society.org
karis-society.org
250.860.9507 (TEL)
250.860.9517 (FAX)

KARIS
SUPPORT SOCIETY

KARIS
REFERRAL

REFERRAL INFORMATION

DATE: ________________

REFERRING AGENT: ____

ADDRESS: ______________________________ **EMAIL**: ___________________________

AGENCY PHONE: _______________________ **AGENCY FAX**: _____________________

RESIDENT INFORMATION

NAME *(first)*: __________________(*middle*): _________________(*last*): _______________

ADDRESS: _____________________**CITY:** __________________ **POSTAL CODE:** _______

PHONE (*home*): ________________________ **PHONE** (*alternative*): _______________

CARE CARD#: __________________**DOB:** __________________ **SIN:** _______________

MARITAL STATUS: ______________**PREGNANT:** ________ **DUE DATE:** ______________

# of CHILDREN: ________________ **# of DEPENDENT CHILDREN:** __________________

NAMES AND AGES OF CHILDREN: ____

____

WHERE DO CHILDREN RESIDE?: ____

____

EMERGENCY CONTACT INFO

NAME: ___________________________ **ADDRESS:** _________________________________

PHONE (*home*): ________________________ **PHONE** (*alternative*): _______________

RELATIONSHIP: ____

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FAMILY PHYSICIAN: ______________________ PHONE: ___________________________

PSYCHIATRIST: __________________________ PHONE: ___________________________

DENTIST: _______________________________ PHONE: ___________________________

PEDIATRICIAN: __________________________ PHONE: ___________________________

ALCOHOL & DRUG COUNSELLOR: ______________________ PHONE: ______________

MENTAL HEALTH WORKER: ____________________________ PHONE: ______________

SOCIAL WORKER: _____________________________________ PHONE: ______________

OTHER PROFESSIONAL/COMMUNITY SUPPORTS: _____________________________

MEDICAL CONDITIONS: ____

____

ALLERGIES: ____

HEAD INJURY/CONCUSSION: YES / NO

DESCRIBE:____

FAMILY HISTORY WITH ALCOHOL, ANY POSSIBILITY OF FETAL ALCOHOL EFFECTS/

SYNDROME: YES / NO

DESCRIBE:____

MENTAL HEALTH

DIAGNOSIS:____

MEDICATIONS/DATE STARTED: *(include dosage)*	CONDITION(S) BEING TREATED:
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

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ARE ANY OF THE FOLLOWING HEALTH RISK BEHAVIOURS CURRENTLY PRESENT?
(within the last 6 months)

BEHAVIOR	CIRCLE ONE	HOW OFTEN	LAST TIME	MANAGEMENT
SEIZURES	YES NO			
SUICIDE ATTEMPTS	YES NO			
SELF-INFLICTED VIOLENCE (EG. CUTTING)	YES NO			
HOSPITALIZATION FOR PSYCHIATRIC ILLNESS	YES NO			

DOES RESIDENT HAVE A HISTORY OF PHYSICAL AND/OR SEXUAL ABUSE?

____

ALCOHOL & DRUG USE SUMMARY

SUBSTANCE USED	YEARS OF USE	DATE OF LAST USE

OTHER ADDICTIONS OF CONCERN *(eg. gambling, shopping):*____________________

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EXPERIENCE WITH:	DATES OR # OF TIMES	CIRCLE ONE	
RESIDENTIAL TREATMENT		COMPLETE	INCOMPLETE
SUPPORTIVE RECOVERY		COMPLETE	INCOMPLETE
DETOX		COMPLETE	INCOMPLETE

DOES RESIDENT HAVE PENDING CHARGES, COURT INVOLVEMENT OR PROBATION / BAIL COMMITMENTS? YES / NO

PLEASE DESCRIBE: ____

____

EDUCATION: ____

DOES RESIDENT HAVE ANY SPECIAL NEEDS? *(eg. literacy, disability)* **YES / NO**

PLEASE DESCRIBE: ____

____

INCOME

INCOME ASSISTANCE	
DISABILITY	
OTHER	
RECEIVING PRENATAL ALLOWANCE	

ADDITIONAL NOTES: ____

____