REFERRAL FORM

DATE:

Please check the appropriate box:

- ☐ Referring agency is requesting consult only at this time
- ☐ Person is aware of referral and willing to engage with ICMT
- ☐ Person is self-referring

People partnering with ICM Team will typically be experiencing:

- **High level of substance use as the primary presenting issue**
- **May or may not have co-occurring mental illness and/or developmental disabilities**
- **Homeless or at risk of homelessness**
- **Barriers to accessing health care**
- **Difficulties connecting to traditional community mental health and substance use services**

Vision

Partnering with people affected by substance use, to live their life in all its fullness by recognizing the person as the author of their own story with a lifetime of rich and diverse experiences.

Mission

ICMT is an inter-disciplinary, outreach team that practices from a harm reduction, strengths-based philosophy and provides individual care to adults who are actively using substances. ICMT respects and acknowledges personal differences and promotes a focus on the assets and abilities of the person and their environment.

Fill out the attached forms and fax to: 250-331-8549
Attention: ICMT
If person is agreeable to the referral please obtain a signed Permission to Connect which is included on page 4 of this package.

Confidential Personal Information Form

APPLICANT:			
Legal First / Last Name:		MRN (if applicable):	
Preferred Name:		Doctor's Name / Location:	
Care Card #:	Birthdate:	Age:	Gender Identity:
Living Situation (Please include address if available): Please also include frequent spots where person may be located in the community:			
Telephone / Contact# Msg OK? Primary # Home: _____ Yes ☐ No ☐ Yes ☐ Cell: _____ Yes ☐ No ☐ Yes ☐ Messages: _____			
List substance(s) of choice, amount and frequency:			
Referred for the following reasons:			
REFERRAL SOURCE:			
Agency: Contact Name: Phone#: Fax#: Address:			

Please include any other information that may be relevant to successfully supporting this person:

PERMISSION TO CONNECT

I, _____, give permission for Comox Valley Intensive Case Management Team to contact the following agencies in order to try and make contact with me:

- ☐ AIDS Vancouver Island (AVI)
- ☐ Wachiay Friendship Centre
- ☐ Substance Use Intervention Nurse
- ☐ Comox Valley Nursing Centre
- ☐ Comox Valley Salvation Army Shelter
- ☐ Comox Valley Transition Society
- ☐ Sunshine Soup Kitchen
- ☐ Courtenay Library
- ☐ Other (Write in space below)

_____

Signature Date

Information can be updated and changed at any time by the person.