CLAREMONT HOUSE SPECIAL CARE UNIT
REFERRAL FORM

Date: _____/_____/_____
dd mm yy

First Name: _____ **Last Name:** _____

Alias or other: _____

D.O.B.: _____/_____/_____
dd mm yy

HCN: _____ **Expiry Date:** _____/_____/_____
dd mm yy

Address: _____

Client Consents to Referral: ☐ **Yes** ☐ **No**

How to Contact Client: _____

Admission criteria:

1. Long history of homelessness and drinking on the street, esp. non beverage alcohol such as mouthwash, rubbing alcohol, Chinese cooking wine, etc
2. Have not benefited from attempts to control drinking
3. Frequent interactions with police, EMS and hospital

Reason(s) for Referral: _____

_____

_____

_____

Referring Agency/Contact: _____

Telephone number: _____

FOR OFFICE USE ONLY – DO NOT COMPLETE THIS PART

Reviewed by : _____

Date for Committee Review: _____

Eligible ☐ Not-Eligible ☐

Date Referral Notified: _____