Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal
Québec

ODIM0309

☐ IUSMD ☐ HSA ☐ CHSM ☐ HGL
☐ HLAS ☐ CHSLD _____

RECOVERY AND SOCIAL INTEGRATION SERVICE / REFERRAL FORM

Nº dossier / Chart nº | DDN / DOB | Sexe / Sex

Nom / Name | Prénom / First Name

Nom de la mère / Name of mother

Adresse / Address

Tél. / Tel.

Nº assurance maladie / Medicare Card Nº | Expiration

IMPORTANT

1. Ensure that the information is complete for processing by the Recovery and Social Integration clinical team.
2. **To be completed by the primary case manager and the person requesting services.**

To be completed by the primary case manager

Name of primary case manager (printed):

Signature of case manager | Professional license number | Date (YYYY/MM/DD)

Job Title:

Service:

Psychiatrist:

Identification of the person requesting services

Email:

Pronouns used (he/she/they):

To be completed by the person requesting services

Share with us the recovery goals, hopes and/or life project(s) that have led you to the Recovery and Social Integration Service:

What are your strengths and resources (personal and social)? (Examples of resources: family, friends, communities, work, education, strategies for managing stress and symptoms, etc.)

Which program(s) or activity(ies) are you most interested in?

☐ Therapeutic physical activities
☐ Online learning center CARS
☐ Horticulture
☐ Art workshops – The Impatients
☐ Peer Support
☐ Employment and study support (IPS)

☐ Please make your choice: (max: 2 choices)

1.

2.

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Nº dossier / Chart nº	Nom / Name	Prénom / First Name

Do you have any concerns regarding your participation in recovery activities (e.g., managing emotions, group activities, flexibility of schedule, individual meetings, etc.)?

What support could facilitate your participation in activities?

Do you use or have you used resources at the Douglas or in the community? If so, which ones?

How motivated are you to participate in recovery activities?
(1= very unmotivated and 10= extremely motivated)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have an existing **PHYSICAL AND/OR MEDICAL CONDITION** that may have an impact on participation?

Comments regarding the request or the scheduling of an appointment:

Authorization relating to the communication of information contained in medical files.

I, _____, authorize my referral team and the Recovery and Social integration Service to exchange any information relevant to my request.
Please ensure that persons signing this form are authorized to do so. if necessary, please indicate in which capacity (guardian or curator) the person is authorized to sign.

Signature (user or authorized person)

Date (YYYY/MM/DD)

Section reserved for the use by the Recovery and Social Integration Service.

The request form and other documents must be sent via email to:

servicesderetablissement.comtl@ssss.gouv.qc.ca