Referrals may be sent to:
Email: npeekeekoot@bmhc.net or Fax: 780 497-7156

Inquiries to the email above or Phone: 780 249-7002

Referral

CLIENT

Client's Preferred Name	
Clients legal name	
Other Name(s) used by Client	
Date of Birth	Age:
Alberta PHN	
Ethnicity	First Nations/Non-Status ☐ First Nations/Status ☐ Metis ☐ Inuit ☐ Caucasian ☐ Other – specify _____
Treaty Number	
Client's contact number	

REFERRAL AGENT

Referral Agency	HER Program ☐ E4C ☐ Catholic Social Services ☐ BMHC ☐ Metis Child and Family Services ☐ Other: _____
Contact Person at Referral Agency	
Contact Phone #	
Contact Fax #	
Contact Email	

PREGNANCY

Client's Due Date	
Client's Plan for Pregnancy	
Receiving Prenatal Care	Yes ☐ No ☐ If yes, please provide details available including name and location of provider, time of last visit etc.
Any Health Complications Related to Pregnancy?	Please provide details
Underlying Health Conditions Impacting Pregnancy or Potentially Impacting Pregnancy	Please provide details
Previous Pregnancies	Yes ☐ No ☐
If Client has had previous pregnancies, please provide details if available (including dates, outcome of pregnancy, current custody or placement of children).	

HOUSING

Please provide information about the Client's current housing situation, and as much as is known, a timeline for the past three years		
Date From Month/Year	Date To Month/Year	Housing Situation
	current	

SUBSTANCE USE

Current Substance Use Details	Please include type(s) of substance(s) used, frequency, and other relevant details.
Harm Reduction Strategies Currently Used	
History of Substance Use Details	

MENTAL HEALTH, FASD and DEVELOPMENTAL DISABILITIES

Diagnosis or Suspected Diagnosis (please list all with details including impacts for Client)

INCOME

Source	Income Supports ☐		AISH ☐	
	Worker name and contact information:			
	Employment ☐		Other ☐	
	Please provide details of employment or other income			

OTHER RISK/SAFETY FACTORS

	Please Provide Details
Work in the Sex Trade	
Violent Relationship	
Gang Involvement	
Suicidal Ideation or Attempts	
Self-Harm	
Violent Tendencies	
Anger/Aggression Issues	
Involvement in the Legal System	
Other Issues	

SUPPORTS CURRENTLY IN PLACE

	Please Provide Details of All Applicable (name, phone number and email addresses if available)
Partner/Spouse	
Other Natural Supports	
Mental Health Worker	
Psychiatrist	
Family Physician	
Probation or Parole Officer	
PDD	
Guardian and/or Trustee	
HUB Financial Management	
Other	

CLIENT GOALS

What are the Clients Current Goals:

CLIENT STRENGTHS

What are the Client's Strengths (as noted by the Client and/or Referral Agent)?

CULTURAL OR SPIRITUAL CONNECTIONS

If applicable, please provide information about any cultural or spiritual traditions, ceremonies or practices that the Client has engaged in or wishes to engage in

I, _____ am in agreement with this referral being made on my behalf. The Boyle McCauley Health Centre's Pregnancy Pathways program has been explained to me and I understand that if I am accepted for Pregnancy Pathways, I will have to agree to the following:

- I will move into housing as assigned to me by Pregnancy Pathways
- I will pay rent based on my income
- I will meet with Pregnancy Pathways staff on a regular basis to create a plan for my time with the Program, and will work with the staff to follow through on my plan.

I, _____ understand that the Boyle McCauley Health Centre's Pregnancy Pathways program needs to collect, use and disclose information about me to help determine suitability for the program. I consent to the collection, use and disclosure of my information. I understand that information shared about me may include personal information, health information, criminal history information and legal information.

This Consent is effective from _____ _____, 20___ and will remain in effect until eligibility for the program is determined or I withdraw my consent, whichever occurs first.

Signature: _____ Print Name: _____

Witness Signature: Witness Name:

_____ _____

Health information is collected, used and disclosed pursuant to sections 20, 27 and 34 of the *Health Information Act.* Other personal information is collected, used and disclosed for the purposes outlined in Sections 33 to 43 of the Freedom of Information and Protection of Privacy (FOIPP) Act, and other legal requirements where they are consistent with the FOIPP Act. If you have any questions regarding the collection, use and disclosure of your information contact: BMHC Privacy Information Officer at 780-422-7333 ext. 247