Biigajiiskaan: Indigenous Pathways to Mental Wellness Referral Form

(Applicant Information be completed by staff)

Referral Date:		
Applicant's First Name:	Applicant's Last Name:	
Preferred First Name (If different from above):		
Spirit Name (If applicable):	Clan (If applicable):	
Date of Birth (DD/MM/YYYY):	OHIP#:	V/C:
Gender: ☐ Male ☐ Female ☐ Non-Binary	Identifies as a member of the LGBTQ2S+ community? ☐ YES ☐ NO	
Indigenous Identification (Please select all that apply): ☐ First Nation ☐ Métis ☐ Inuit ☐ Non-Indigenous	Band/Nation (if applicable):	
Has Status: ☐YES ☐NO		
Status Card:	Registry Number:	
Please list any accommodations required during appointments: (i.e. Interpreter):		
Applicant's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Common-Law ☐ Widowed		
Applicant's Address:	City/town:	
Province:	Postal Code:	
Applicant's Email Address:		
Applicant's Primary Phone Number:	Applicant's Secondary Phone Number:	
Okay to leave voice messages: ☐YES ☐NO Okay to send text messages: ☐YES ☐NO		
Has a Primary Care Provider (e.g. *Family doctor, Nurse Practitioner):* ☐YES ☐NO Provider Name: Provider Phone Number: Provider Address:		
Has a Psychiatrist*:* ☐YES ☐NO If yes, Psychiatrist Name: Psychiatrist Phone Number: Has a Traditional Healer ☐YES ☐NO If Yes, Traditional Healer Name: Traditional Healer Phone Number:		

Is the person being referred already a client of St. Joseph's Mental Health Services? ☐ YES ☐ NO

If YES, What Program: _____

Primary Clinician: RL Number:

Has a Public Guardian and Trustee (PGT): ☐ YES ☐ NO

If yes, PGT Name: PGT Phone Number:

Has a Substitute Decision Maker (SDM): ☐ YES ☐ NO

If yes, SDM Name: SDM Phone number:

Has a Community Treatment Order (CTO): ☐ YES ☐ NO

If Yes, Date CTO Issued: (DD/MM/YYYY)

Emergency Contact Name:	Relationship to applicant:
Emergency Contact's Phone Number:	Emergency Contact's Home Address:

Please list below any other care providers that are supporting the applicant (If applicable)

Organization	Contact Person	Contact Phone Number	Nature of Services provided

Referral Information

First and last name of referring staff member:

Phone Extension: Referring staff email address:

Referring staff member's organization:

Applicant's program/unit:

How did the applicant hear about Biigajiiskaan?

Has the applicant previously attended Biigajiiskaan's programming or services? ☐ YES ☐ NO
If yes, which services:

Has the applicant previously attended Atlohsa's programming or services? ☐ YES ☐ NO
If yes, which services:

Reason for Referral

Describe Concerns with mental wellness (severe and/or persistent symptoms, self-harm, suicide, etc.):

Describe additional wellness needs (building cultural identity, mental health or other medication needs, housing, income, education, social supports, life skills, etc.):

Wellness Checklist

Is the applicant currently experiencing, or have they experienced any of the following in the past:

- ☐ Suicidal thoughts
- ☐ Self-harm
- ☐ Aggressive or violent behavior
- ☐ Feelings of depression/ anxiety
- ☐ Delusions/Hallucinations
- ☐ Fear/Paranoia
- ☐ Post-Traumatic Stress
- ☐ Intergenerational Trauma
- ☐ Abuse
- ☐ Martial/Custodial Issues
- ☐ Grief/Traumatic Loss

Please describe:

Medical Information

Please list any medical conditions or health issues of the applicant:
Please list any allergies (including sensitivity to burning traditional medicines):
List of medications or traditional medicines used:
Please list any known mental health diagnoses:

Substance Use

Is the applicant currently experiencing substance abuse? ☐YES ☐NO
Has the applicant experienced substance abuse in the past? ☐YES ☐NO
Has the applicant utilized any programs or services to address substance abuse? ☐YES ☐NO If yes, please list:
Is the applicant looking for support in this area? ☐YES ☐NO

Housing and Income

Does the applicant have stable housing? ☐YES ☐NO If no, please explain:
What is the applicant's source(s) of income?