

4615 Côte Saint Catherine Road | Montréal, Quebec | H3W 1M1 | Phone: 514-738-7700 | Fax: 514-738-6166

CHABAD LIFELINE REFERRAL FORM

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| Date of Referral: | | | | | |
| Client’s name: | | | Age: | | D.O.B. (d/m/y): |
| Address: | | | | | |
| City: | Province: | | | Postal Code: | |
| Home Phone: | | May we leave a message? 🞎 Yes 🞎 No | | | |
| Cell Phone: | | May we leave a message? 🞎 Yes 🞎 No | | | |
| Email address: | | May we email? 🞎 Yes 🞎 No | | | |
| Parent/Guardian if under 18: | | Are parents aware of referral? 🞎 Yes 🞎 No | | | |

Referring Professional

|  |  |  |
| --- | --- | --- |
| Name: | | |
| Practice: | | |
| Address | | |
| City: | Province: | Postal Code: |
| Phone: | | |
| Email: | | |

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| Reasons for Referral (presenting problem/s): |

Please describe the following:

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| Substance addiction history: |
| Process/behavioural addiction history: (i.e. cyber addiction, gambling, sex addiction, etc.) |
| Mental Health History: |
| Significant Medical/Health History: |
| Current Prescribed Medications: |

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| Current Resources/Supports in Place: |

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| Office Use: Received by  Counsellor Signature Date |

**NOTE: In addition to this referral, prospective clients must call in themselves to access our services: 514-738-7700.**

(REVISED – 03/18/24)