Vancouver CoastalHealth
Promoting wellness. Ensuring care.

DEAF WELL-BEING PROGRAM

# ADULT REFERRAL FORM

Address: #300-4211 Kingsway, Burnaby BC V5H 1Z6
Phone Number: 604-456-0900
TTY Number: 6054-456-0901
FAX Number: 604-456-0904
**Email: WellBeing.Staff@vch.ca**

Today's Date (dd-mmm-yy): _____

Reason for referral: _____

## Client Information (please print)

Last Name: _____ First Name: _____

Preferred Name: _____ PHN: _____

Date of Birth (dd-mmm-yy): _____ Age: _____ Self-identified Gender: M ☐ F ☐ Transgender ☐

Address: _____
(Please include city and postal code)

Home Phone: _____ Can we leave a message/text at this number: ☐Yes ☐No

Cell Phone: _____ Can we leave a message/text at this number: ☐Yes ☐No

Email: _____

Emergency Contact & Phone Number: _____

Family Physician: _____ Phone: _____

## Language

Deaf: ☑ Hard of Hearing: ☐ Deaf-Blind: ☐ Deafened: ☐

Preferred method of communication: _____

## Past Support/Other People Involved

Have you (client) had counselling or mental health services before? ☐Yes ☐No

If yes, please tell us who provided the service and when:

_____

_____

_____

_____

Are there any other professions involved in supporting you (pediatrician, social worker, other)?

☐Yes ☐No

If yes, please list:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

How can the Deaf Well-Being Program help you?

_____

_____

_____

_____

Have you an immediate concerns today, safety etc?

_____

_____

_____

_____

How did you hear about our services?

_____

_____

_____

Additional notes:

_____

_____

_____

**For Office Only**

| Health Authority Region | Last Name, First Name | PARIS ID |
|---|---|---|
| | | |