



Grand Bend Area Community Health Centre
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SOCIAL WORK REFERRAL FORM

Date of Referral _____
 Patient Name _____
 Address _____
 Contact # _____ OHIP# _____
 Birth Date _____ Day _____ Month _____ Year

Marital Status single married separated common law widowed divorced

Referral Source self family member physician health care provider other

Referral Source Name _____
 Address _____
 Contact # _____

Reason for Referral Patient Presents with following concerns

<p>Psychosocial Issues Role changes Spousal / partner conflict Parenting concerns Family conflict Care-giver distress Loss of employment Social isolation Decreased support systems Financial distress Possible abuse / neglect</p>	<p>Emotional/ Behavioural Changes Increased stress with decreased coping skills “Emotional overlay” (i.e. anxiety, grief, helplessness, fear, anger, guilt, symptoms of depression) Alcohol and /or substance abuse Suicidal ideation and/or plan “acting out” behaviours (i.e. agitation, irritability) Trust issues</p>	<p>Physical Changes Headaches Nausea Increased subjective pain symptoms Disruptive sleep patterns Change in eating habits Decreased energy Agitation / restlessness Possible signs of abuse / neglect</p>	<p>Adjustment Due to Illness or Disability Role changes due to illness / disability Decreased coping mechanisms Changes due to family dramatics, roles and responsibilities Care giver distress</p>
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Additional Comments Please:

Thank you for the referral to Social work Services. The patient will be contacted within 24 hours.
 If this is URGENT please leave a telephone message as well.

