

COAST Referral

Date (yyyy-mm-dd): _____

Name: (First, Last, Middle)	DOB(yyyy-mm-dd)
Address	City
Phone:	Alternate:
Next of Kin:	Next of Kin #:

Referral Source

Name (First, Last)	
Phone:	Email:
Agency, Program, Position	
Has the client consented to sending COAST Referral? <input type="radio"/> Yes <input type="radio"/> No	
Written consents attached? <input type="radio"/> Yes <input type="radio"/> No	

Presenting Issues/ Risk Factors

<input type="checkbox"/> Violence toward others	<input type="checkbox"/> Sexual Aggression	<input type="checkbox"/> Concealing weapons
<input type="checkbox"/> Violence toward self	<input type="checkbox"/> Thought Disturbance	<input type="checkbox"/> Substance Use
<input type="checkbox"/> Suicide attempt (within 24 hrs)	<input type="checkbox"/> Criminal involvement	<input type="checkbox"/> Homelessness
<input type="checkbox"/> Suicide Risk	<input type="checkbox"/> Criminal Victimization	<input type="checkbox"/> Missing

Reasons/Factors contributing to referral: Please include hallucinations, delusions, aggression etc. Note any skills/strategies person has successfully used when in crisis.

Fax Referral to COAST at 226-401-3823

Call Crisis Services at 519-759-7188 to confirm receipt of referral and to clarify details.

Note: Referral is not appropriate if client is at immediate risk of suicide/harming others and is not in a safe location. In those situations, call 911 for immediate response.