This is confidential and intended solely for the use of whom it is addressed. If you have received this in error, please return to the sender and permanently discard this.

Priority Community Referral (PCR)

Contact Information

Date: ______________________ **Time:** ______________

Name: ______________________ **Identified Gender:** ______________

DOB (mm/dd/yy) ____/____/____ **Diagnosis:** ______________

Address: ______________________ **Family Doctor:** ______________

Phone: ______________________ **Psychiatrist:** ______________

Reason for referral to hospital

Risk Factors	Explanation
☐ Danger to self ☐ Plan ☐ Means ☐ Intent ☐ History	
☐ Danger to others ☐ Plan ☐ Means ☐ Target ☐ History	
☐ Unable to care for self	
☐ Other	

Medications ______________________

____

____

____

Pharmacy

☐ **Unknown**

Name: ______________

Address: ______________

Phone: ______________

Risk factors to be considered before discharge ______________________

____

____

Referral Source

**Will receive discharge information from NHS*

Agency: ______________________

Name: ______________________

Phone: ______________________

Fax: ______________________

Other Agency Involvement

Agency/Worker: ______________________

____

Agency/Worker: ______________________

____

Agency/Worker: ______________________

____

Complete form and fax to PERT 905-704-4755