The Salvation Army Edmonton Centre of Hope
Stabilization Housing Program Referral Form

Date received:	Reviewed by:	On waitlist?: Yes ☐ No ☐	Intake Date:	Bed #

Personal Information

Name:	Date of Birth:
Treatment/Housing Intake Date:	Estimated Discharge Date:
Type of Funding: AB Works ☐ AISH ☐	
Other ☐	Funding File Number:
Gender: Male ☐ Female ☐ Non-Binary ☐ Other ☐ Prefer not to disclose ☐	
Contact number or Email:	
Alberta Health #:	Other Provincial Health Care #:
Communicable disease: Yes ☐ No ☐	Type?
Identifies as Aboriginal/First Nations, Inuit, Metis: Yes ☐ No ☐	Where are you from?
Status? Yes ☐ No ☐	Status #:
Primary Care Physician Name and Contact #:	
Reason for Referral to the Stabilization Program:	
Goal(s) participant is hoping to achieve by accessing this program:	
Referral Agent Information:	
Name:	
Role/Title:	
This person has been assessed: Yes ☐ No ☐	Needs medical detox? Yes ☐ No ☐
I will no longer support this person after intake to this program: Yes ☐ No ☐	
Health Concerns/Medications of Note/Medical Notes:	

Medications * Please have participant prepared with paper prescriptions for at least 30 days of currently-prescribed medications.* *Please send any medications with participant in blister type packaging.

1 Name:	Reason:	How long have they been prescribed this?
2 Name:	Reason:	How long have they been prescribed this?
3 Name:	Reason:	How long have they been prescribed this?
4 Name:	Reason:	How long have they been prescribed this?
5 Name:	Reason:	How long have they been prescribed this?
6 Name:	Reason:	How long have they been prescribed this?
7 Name:	Reason:	How long have they been prescribed this?
8 Name:	Reason:	How long have they been prescribed this?
9 Name:	Reason:	How long have they been prescribed this?
10 Name:	Reason:	How long have they been prescribed this?

Prescription Coverage Type: AB Works ☐ AISH ☐ Employment ☐ Self Pay ☐
Mental Health Concerns/Diagnosis:
Further knowledge that will support the staff in providing the best outcome for this Participant: