

Rapid Assessment Intervention and Treatment (RAIT) Request for Services

\* Is the individual aware that a request for service is being made? [ ]  **Yes** [ ] **No**

Is this a d/c referral from hospital - [ ]  **Yes** [ ]  **No**

**Section A: Referring Healthcare Practitioner Information**

Date: (DD/MM/YY) Referral Time: **(24 hour time system)**

Primary HCP/NP: Phone Number

**Referring Physician OHIP Billing Number:**

**Physician’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Concern: (please provide a specific explanation for request for service vs. one word answer. i.e. depression)

 **Section B: Personal Information**

Legal Client Name: Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: (DD/MM/YYYY) Age: Health Card:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code:

Phone # 1: [ ]  Okay to leave message

Phone #2:

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Phone # ☐ Okay to leave message

 **Section C: Medical Conditions**

Please list any medical conditions that may be relevant to this referral or important for the RAIT team member to be aware of:

**Fax completed form to:** **Chatham-Kent (519) 351-9203 Sarnia (519) 337-2325**

**\*The RAIT Program will respond as soon as possible, but no later than 1 business day\***