



*For pregnant and/or parenting women (children ages 0-6)
who have been/are currently struggling with substance use*

Belleville and Quinte West Community Health Centre – Thrive Program Referral

REFERRED BY			
Name:		Agency/Org.:	
Phone #:		Fax #:	
Date of Referral (dd/mm/yyyy):			

INDIVIDUAL INFORMATION			
Name:		Phone #:	
DOB (dd/mm/yyyy):		Health Card #:	
Address:			
City:		Postal Code:	
Alternate Contact:		Phone #:	
Primary Care Provider:		Phone #:	

THRIVE CRITERIA		
Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Parenting (children ages 0-6)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Substance use; using or at risk of relapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:

OTHER RISK FACTORS		
Harm to Self / Others	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Inability to Care for Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Housing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Financially Unstable	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Legal Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	

OTHER RELEVANT INFORMATION	
Relevant information attached (medical history, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Consent	
Individual aware of referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No