# 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<br>□ Plan<br>□ Means<br>□ Intent<br>□ History | |
| ☐ Danger to others<br>□ Plan<br>□ Means<br>□ Target<br>□ History | |
| ☐ Unable to care for self | |
| ☐ Other | |

## Medications

_____

_____

_____

_____

## Pharmacy

**Name:** _____

**Address:** _____

☐ **Unknown** **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**