|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | |  |  |   **Recipient - Telephone**   |  |  | | --- | --- | | CIUSSS de l’Est-de-l’Île-de-Montréal - 514 524-3288 | FOR THE GUICHET  Reception Date | | Montreal West Island Integrated University health and social Center 514 363-3025, p. 2257 | | CIUSSS West Central Montreal - 514 488-5552 p. 1250 | | CIUSSS du Nord-de-l’Île-de-Montréal - 514 384-2000, p. 8332 | | CIUSSS du Centre-Sud-de-l’Île-de-Montréal - 514 527-4525 |   **ACCESS GUICHET ID-ASD-PD REQUEST FORM** |

|  |
| --- |
| **NOTE**  *All fields marked with an asterisk (\*) are mandatory. An incomplete request could be returned to you.*  *Please fill the request in capital letters.* |

|  |
| --- |
| 1. **IDENTIFICATION** |

**User Identification**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| \*LAST NAME | | | | \*FIRST NAME | | |
|  | | | |  | | |
| \*DATE OF BIRTH | \*AGE | | \*HEALTH INSURANCE NUMBER | | | \*EXPIRATION |
|  |  | |  | | |  |
| \*SEX : |  | | Female | | | Male |
| \*SPOKEN LANGUAGE :  French | | English | | | Others : | |
| Quebec Sign Language (LSQ) | | | | | American Sign Language (ASL) | |
| \*MOTHER’S LAST NAME AT BIRTH : | | | | | | |
| \*MOTHER’S FIRST NAME AT BIRTH : | | | | | | |
| CIVIL STATUS  :  Canadian  Permanent resident  Refugee  Other : | | | | | | |

**Living Environment**

|  |  |  |
| --- | --- | --- |
| House/Apartment | Foster family | Family-Type Resource (FTR) |
| Parent’s Home | Intermediate Resource (IR) | Nursing Home (CHSLD) |
| Group Home | Other : |  |

**Address**

|  |  |
| --- | --- |
| Resource name (if applicable) : | |
| \*Address : | \*Apartment : |
| \*City : | \*Postal Code : |
| \*Home phone number : | TTY/TTD |
| Cell phone number : | Reach me by text |
| Work Phone number : | Extension : |
| E-Mail: | |

**In case of emergency**

|  |  |  |  |
| --- | --- | --- | --- |
| Last name : | | First name : | |
| Relationship : | | Phone number : | |
| Spoken language :  French | English | | Other : |
| Quebec Sign Language (LSQ) | | American Sign Language (ASL) | |
| Interpreter request Specify : | | | |
| Last name of parent 1  mother  father | | First name of parent 1  mother  father | |
| Last name of parent 2  mother  father | | First name of parent 2  mother  father | |

**Using the phone is difficult, please contact:**

|  |  |
| --- | --- |
| Same as emergency contact | |
| Last Name : | First Name : |
| Relationship : | Phone : |

|  |  |  |  |
| --- | --- | --- | --- |
| Compensation Plan :  CNESSST | SAAQ | | Other : |
| File Number : | | Date of accident/event : | |
| Compensation Agent : | Phone Number: | | Extension: |
| Rehabilitation intervener : | Phone Number: | | Extension: |

|  |  |
| --- | --- |
| 1. **FILL OUT ONLY IF ADULT** | |
| **Occupation :** | Worker  Retired  Social Security  Student  Other, specify: | |
| **Marital Status :** | Single  Common-Law  Married Separated/divorced  Widower | |
| **Living environment** **:** | Lives alone  With Spouse With parent(s)  With children | |

|  |  |  |  |
| --- | --- | --- | --- |
| Protection regime : | Yes | No | File number if known : |
| Name of Legal representative: | |  | Phone number : |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Fill out if minor** | | | | | | | | | |
| The child lives with : | Two Parents | | Father | | Mother | |  | Joint Custody | |
| Other : | | | | | | | | | |
| Custody : | Two Parents | Father | | Mother | | Joint Custody, specifics : | | | |
| Other : | | | | | | | | | |
| Legal Context : | LSSSS | | | LPJ | | | | | LSJPA |

**Contact details of legal guardian or tutor:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Language spoken: | French | English | | Other : |
| Quebec Sign Language (LSQ) | | American Sign Language (ASL) | |
| Tutor 1: | | Tutor 2: | | |
| Address:  Same as user, or : | | Address:  Same as user, or: | | |
| Home phone number : | | Home phone number : | | |
| Other phone number | Cell phone  Work ext. : | Other phone number | | Cell phone  Work ext. : |
| E-Mail : | | E-Mail : | | |

|  |  |
| --- | --- |
| 1. **\* MEDICAL INFORMATION** |  |
| Main Diagnosis : | |
| Specify : | |
| Diagnosis or Event’s Date : | |
| Other Diagnosis or Associated Conditions (ex : medical illnesses): | |
| Specify : | |
| Last name of doctor(s) on file: | First name of doctor(s) on file: |
| Institution: | |
| Address : | |
| \*Phone number : | Extension: |

|  |  |
| --- | --- |
| 1. **\*INFORMATION ON THE SITUATION** |  |
| Status report (concerns and impacts) | |
| Specify : | |
| Trigger (why now) | |
| Specify : | |
| Identified needs of user and family: | |
| Specify : | |
| Interventions/Previous follow-ups (solutions tried) | |
| Specify : | |
| Risks factors / Protection factors (Ex: risks related to mental health and addictions, suicidal thoughts of user /caregiver, network of user) : | |
| Specify : | |

|  |  |
| --- | --- |
| 1. **\*REASON FOR REFERRAL** |  |
| Specify : | |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **REFERRING PROFESSIONAL** | |  | |
| **Name of person who filled out the form** | | | |
| Referent | Family  User | | Other : |
| \* Last name : | | \* First name: | |
| Address : | | | |
| City : | | Postal Code : | |
| \*Phone number : | | Extension : | |
| E-mail : | |  | |
| Title : | |  | |
| Institution : | |  | |

|  |  |  |
| --- | --- | --- |
| \* Signature | Professional title | \* Date (yyyy-mm-dd) |

|  |
| --- |
| **\*I understand that involved institutions must communicate amongst themselves to assess the request.**  **\*I am attaching the *Authorization to release information contained in the medical record*, even if exchanging informations within the same CIUSSS.**  **\*I confirm that informations on this form are accurate and true :** |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Or verbal agreement  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of user or legal representative Date (yyyy-mm-dd)

if user is under legal incapacity of younger than 14 years old

**If user has a motor disability keeping him/her from signing, please give motive and have two witnesses sign.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name in capital letters and signature of witness 1 Date (yyyy-mm-dd)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name in capital letters and signature of witness 2 Date (yyyy-mm-dd)

|  |  |
| --- | --- |
| **7. COORDONNÉES DES GUICHETS D’ACCÈS** |  |
| To access services, a request for services must be made through the **Access Guichet ID-ASD-PD** of the person’s territory of residence who will assess the request. Users can always go to the psychosocial or centralized entry point of their territory’s CLSC.  You will find all pertinent information on the internet site of the *Portail Santé Montréal*, in the section : guichet d’accès DI-TSA-DP : <https://www.santemontreal.qc.ca> | |
|  | |
| **Centre Intégré Universitaire de Santé et de Services Sociaux de l’Est-de-l’île-de-Montréal** | |
| 2909, Rachel East, bureau 441, Montréal (Québec) H1W 0A9, Phone : 514 524-3288  [guichet.unique.di-tsa-dp.cemtl@ssss.gouv.qc.ca](mailto:guichet.unique.di-tsa-dp.cemtl@ssss.gouv.qc.ca), Fax: 514 524-3280 | |
| * CLSC de Mercier-Est-Anjou | * CLSC de St-Léonard |
| * CLSC de l’Est-de-Montréal | * CLSC Hochelaga-Maisonneuve |
| * CLSC de Rivières-des-Prairies | * CLSC Lucille-Teasdale |
| * CLSC de St-Michel | * CLSC de Rosemont |
| * CLSC Olivier-Guimond |  |
| **Centre Intégré Universitaire de Santé et de Services Sociaux du Nord-de-l’île-de-Montréal** | |
| 1425 Jarry Est, Montreal (Quebec) H2E 1A7, Phone : 514 384-2000, poste 8332  [ga.ditsadp.cnmtl@ssss.gouv.qc.ca](mailto:ga.ditsadp.cnmtl@ssss.gouv.qc.ca), Fax: 514 495-6798 | |
| * CLSC d'Ahuntsic | * CLSC de Bordeaux-Cartierville |
| * CLSC de La Petite-Patrie | * CLSC de Montréal-Nord |
| * CLSC de Saint-Laurent | * CLSC de Villeray |
| **Montreal West Island Integrated University health and social Center** | |
| 8000, Notre-Dame West, Lachine (Quebec) H8R 1H2 Phone : 514 363-3025, poste 2257  [guichet-acces-di-tsa-dp.comtl@ssss.gouv.qc.ca](mailto:guichet-acces-di-tsa-dp.comtl@ssss.gouv.qc.ca), Fax : 514 363-3905 | |
| * CLSC de Dorval-Lachine | * CLSC de Pierrefonds |
| * CLSC du Lac-Saint-Louis | * CLSC de Lasalle |
| **CIUSSS West Central Montreal** | |
| 7000, Sherbrooke Street West, Montreal (Quebec) H4B 1R3, Phone: 514 488-5552 poste 1250  [guichet.ditsadp.ccomtl@ssss.gouv.qc.ca](mailto:guichet.ditsadp.ccomtl@ssss.gouv.qc.ca), Fax : 514 488-8132 | |
| * CLSC de Benny Farm | * CLSC de Côte-des-Neiges |
| * CLSC Métro | * CLSC de Parc-Extension |
| * CLSC René-Cassin |  |
| **Centre Intégré Universitaire de Santé et de Services Sociaux du Centre-Sud-de-l’île-de-Montréal** | |
| 6363, Hudson Road, Montreal (Quebec) H3S 1M9, Phone : 514 527-4525  [aeo-ditsadp.ccsmtl@ssss.gouv.qc.ca](mailto:aeo-ditsadp.ccsmtl@ssss.gouv.qc.ca), Fax : 514 510-2204 | |
| * CLSC des Faubourgs | * CLSC du Plateau-Mont-Royal |
| * CLSC de Saint-Henri | * CLSC Saint-Louis-du-Parc |
| * CLSC de Ville-Émard-Côte-Saint-Paul | * CLSC de Verdun |
|  | |