Ministry of Health, Environment & Sustainability
Cayman Islands Government

Poinciana Rehabilitation Centre
Cayman Islands Government

Referral Form

Referent Information

Name: _____

Title: _____

Organization: _____

Phone Number: _____ Email Address: _____

Client's Information

Name: _____

First Middle Last

AKA's: _____

Gender: ☐Male ☐Female Date of Birth: _____ Age: _____

Address: _____

District: ☐East End ☐Bodden Town ☐Northside ☐George Town ☐ West Bay

P.O. Box & Postal Code: _____

Other Address (if applicable):

_____

City & State:

_____

State: _____

Country: _____

Phone Number: _____ E-mail Address: _____

Emergency Contact Information:

Name: _____

Relationship to Client: _____

Phone Number: _____ E-mail Address: _____

Source of Referral:

☐H.S.A ☐DCR/HMCIPS ☐Local Private Institution/Doctor

☐Court Designate Other:_____

Diagnosis

Schizophrenia Spectrum Disorders: ☐Schizophrenia ☐schizoaffective disorder ☐Others: _____

Mood Disorders: ☐Depression ☐bipolar I ☐ bipolar II ☐ Other _____

Trauma Related and Anxiety Disorders: ☐PTSD ☐GAD ☐ Other _____

Substance Use Disorders: ☐ Cannabis ☐Cocaine ☐Alcohol ☐Tobacco ☐Other:_____

Other Disorder: _____

Current Treatment Plan

Is the client currently receiving mental health treatment? ☐ Yes ☐ No

If yes, please give details

_____
_____
_____
_____
_____

Reason for Referral:

_____
_____
_____
_____
_____
_____
_____
_____

Signature of Referent_____ **Date** _____