Vancouver Coastal Health
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

CLIENT REFERRAL - MENTAL HEALTH & ADDICTIONS

Name: **PARIS ID:**
DOB: **Age:** **PHN:**
Gender: **Phone:**
Home Address:

Client Aware: ☐ **Family Aware:** ☐

Referral Details

Referred to Team: **Referral Date:**

Referral Reason: **Priority:**

Referring Source Details

Referral Source: **Referrer to stay anonymous:** ☐

First Name: **Last Name:**

MHA Minimum Reporting Requirements [MRR]

☐ **First Service Event**

Group Information

Group Name: **Group ID:**

External Agencies/Other Professionals

Organization	Relationship	Telephone	Address

Referral Casenote

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

-- End of Report --