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| CISSS_Laval_N_B  Version électronique | | | | | | | | | | | | | | | | | | | | | | | | | | **Formulaire de référence**  Demande de services externes  Hôpital juif de réadaptation | | | | | | | | | | | | | | | | | | |
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| **Nous joindre :** | | | | | |  | | | | | | | | | | | | | | | | | | | | **Date de réception ▶** | | | | | | | | | **À L’USAGE DU GUICHET** | | | | | | | | | |
| 3205, place Alton-Goldbloom Laval (Québec) H7V 1R2 | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tél. 450 688-9550, poste 213 | Téléc. 450 688-0421 | | | | | | | | | | | | | | | | | | | | | | | | | |
| Courriel : aeoexterne\_hjr@ssss.gouv.qc.ca | | | | | | | | | | | | | | | | | | | | | | | | | |
| Site web : www.lavalensante.com | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. Référent | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOM DU RÉFÉRENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | COURRIEL | | | | | | | | | | | | | | | |
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| TITRE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | TÉLÉCOPIEUR | | | | | | | | | | | | | | | |
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| ÉTABLISSEMENT/PROGRAMME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | TÉLÉPHONE | | | | | | | | | | | | | POSTE | | |
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| **Consentement** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L’usager ou son représentant a été informé et consent à la référence et à la transmission de l’information à son sujet : | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Oui | | |  | | | | Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. Identification | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Identification de l’usager** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOM DE FAMILLE | | | | | | | | | | | | | | | | | | | | | | | | | PRÉNOM | | | | | | | | | | | | | | | | | | | |
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| DATE DE NAISSANCE | | | | | | | | | | | | | | | | ÂGE | | | | | | | | NAM | | | | | | | | | | | | | | | | EXPIRATION | | | | |
|  | | | | | | | | | | | | | | | | ans | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | |
| SEXE | | | | | | | | | | | | | | | | LANGUE PARLÉE | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Féminin  Masculin | | | | | | | | | | | | | | | | Français  Anglais  Autre(s) : | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Statut civil 🞂 | | | | Célibataire | | | | | | | | | | | | Conjoint de fait | | | | | Marié(e) | | | | | | | | | | Séparé(e)/divorcé(e) | | | | | | | | | | | | Veuf(ve) | |
| Milieu de vie 🞂 | | | | Seul(e) | | | | | | | | | | | | | | | | RI-RTF | | | | | | | | Famille d’accueil | | | | | | Autre, précisez : | | | | | | | | | | |
| Autre personne significative | | | | | | | | | | | | | | | | CJ | | | | | | | | Garde partagée | | | | | |
| Parent(s) | | | | | | | | | | | | | | | | CHSLD | | | | | | | | Monoparentale | | | | | |
| **Adresse de l’usager** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ADRESSE (numéro, rue, ville) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | CODE POSTAL | | | |
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| TÉL. DOMICILE | | | | | | | | | | | | | TÉL. CELLULAIRE | | | | | | | | | | | | | TÉL. TRAVAIL | | | | | | | | | | COURRIEL | | | | | | | | |
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| **Coordonnées des parents** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Même adresse que l’usager** | | | | | | | | | | | | | | | | | | | | | | | | | | | **Même adresse que l’usager** | | | | | | | | | | | | | | | | | |
| NOM ET PRÉNOM DE LA MÈRE – **OBLIGATOIRE** | | | | | | | | | | | | | | | | | | | | | | | | | | | NOM ET PRÉNOM DU PÈRE – **OBLIGATOIRE** | | | | | | | | | | | | | | | | | |
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| ADRESSE (si pertinent) | | | | | | | | | | | | | | | | | | | | | | | | | | | ADRESSE (si pertinent) | | | | | | | | | | | | | | | | | |
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| TÉL. DOMICILE | | | | | | | | | | | | | | TÉL. CELLULAIRE | | | | | | | | | | | | | TÉL. DOMICILE | | | | | | | | | | TÉL. CELLULAIRE | | | | | | | |
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| TÉL. TRAVAIL | | | | | | | | | | | | | | COURRIEL | | | | | | | | | | | | | TÉL. TRAVAIL | | | | | | | | | | COURRIEL | | | | | | | |
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| **Agent payeur** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CNESST (CSST) | | | | | | | | | | | IVAC | | | | | | | | | | | | | | SAAQ | | | | | | | | No dossier : | | | | | | | | | | | |
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| 3. Renseignements médicaux | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diagnostic principal :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Précisez : | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date d’évènement /chirurgie /apparition de la maladie (si applicable) : | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **Autres diagnostics et conditions associées :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Précisez : | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4. Mesures légales | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *(Protection de la jeunesse, régime de protection, ordonnance et autres)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Précisez : | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5. Information sur la situation | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **État de la situation (problématique et impact)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Précisez : | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Élément déclencheur (pourquoi maintenant) :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Précisez : | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Besoins identifiés par l’usager et sa famille :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Précisez : | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Interventions/suivis antérieures (solutions tentées) :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Précisez : | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Facteurs de risque et de protection (Ex. : risques liés à des problématiques de santé mentale et dépendance, idéations suicidaires chez l’usager et proche aidant, forces, réseau de la personne) :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Précisez : | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 6. Motif de la référence | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Précisez : | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Note : Se référer à l’aide-mémoire afin de compléter et joindre les documents obligatoires.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 7. Personne lien | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Personne à contacter (autre que les parents)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOM DE FAMILLE | | | | | | | | | | | | | | | | | | | PRÉNOM | | | | | | | | | | | | | | | | | | | | LIEN | | | | | |
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| TÉL. DOMICILE | | | | | | | | | | | | | TÉL. CELLULAIRE | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
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| 8. Nom de la personne ayant complété la demande | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | |  | date | | | | |  |
|  | Nom | | | | | | | | | | | | | | | |  | Fonction | | | | | | | | | | | | | | | | | | | |  | Date | | | | |  |