Community Mental Health and Addictions Services Referral Form

If this is an emergency, call 911 or your local crisis services

If Faxed Include Number of Pages (Including Cover): ____ Pages **Date of Referral _____**

Identifying Information for Person Being Referred

Last Name: _____ First Name: _____

Preferred/Alternate Name: _____

Date of Birth:_____ Age: ____ Gender: Aboriginal Status:

Health Card #: _____ Version Code: ___ Province Issuing Health Card:

☐ No Health Card ☐ No Version Code

Current Address: _____ City: _____ Province:

Postal Code: _____ ☐ No known address

Telephone: _____ Alternate Telephone: _____ ext. ____ ☐ No known telephone

Language first spoken: ◉ English ◯ French ◯ Other (specify): _____

Aboriginal Languages (if applicable): _____

In which of Canada's official languages is person being referred most comfortable? ☑ English ☐ French

Name of Alternate Contact Person: _____ OK to contact if required? ◯ Yes ◯ No

Telephone: _____ ext.: ____ Cell No.: _____

Relationship to person referred (check all that apply): ☐ Power of Attorney ☐ Substitute Decision Maker
☐ Spouse ☐ Family Member ☐ Friend ☐ Case Worker ☐ Elder ☐ Other: (specify)

Address for services (if different than Home Address): _____
City: _____ Province: _____ Postal Code: _____

Telephone: _____ ext. ___ Alternate Telephone: _____ ext.: ____ ☐ No known telephone

Contact Information

Conduct call back with: ☐ Person being referred Best time to call: _____ OK to leave message? ◉ Yes ◯ No
(Check all that apply) ☐ Alternate Contact Best time to call: _____ OK to leave message? ◯ Yes ◯ No
☐ Person being referred wishes to be contacted by email - Email address: _____

Please check all accessibility or functional challenge(s) the referral recipient(s) should be aware of:
☐ Interpreter required ☐ Cognitive ☐ Literacy ☐ Physical/Mobility ☐ Hearing ☐ Visual ☐ Other: _____

Details: _____
Current Agencies/Services Involved: _____

Referral Source

Name: _____ Role/Title: _____ Organization: _____

Telephone: _____ ext.: _____ Fax #: _____

Relationship to person being referred: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Agency ☐ Care Provider ☐ Other

Is the person being referred aware of the referral? ◯ Yes ◯ No

☐ The person being referred consented to the referral. Date consent provided:

☐ Acknowledgement of referral receipt requested by referring agency.

Referral for: Last Name: _____ First Name: _____

Psychiatric Information

Does the person being referred have a psychiatric diagnosis? ◉Yes ○No ○Unknown

If yes, what is the diagnosis? _____

Is the person being referred currently receiving care from a psychiatrist? ○Yes ◉No ○Unknown

Name of Psychiatrist: _____ ☐No ☐ Unknown

Telephone: _____ ext.: ___ ☐Unknown Fax #: _____ ☐Unknown

Medical Care Provider Information

Is the person being referred currently receiving care from a family doctor or nurse practitioner? ○Yes ◉No ○Unknown

Name of family doctor or nurse practitioner: _____ ☐ Same as referral source ☐ Unknown

☐ Person being referred does not have a family doctor or nurse practitioner

Telephone: _____ ext.: ____ ☐Unknown Fax #: _____ ☐ Unknown

Requested Services

Reason for referral: _____

Requested services - check all that apply:

☐ Mental Health

☐ Addictions or Substance Misuse

☐ Problem Gambling

☐ Family Counselling

☐ Legal

☐ Psychosocial supports

☐ Sexual Assault Counselling

☐ Supportive Housing

☐ Other (please specify) in details

☐Psychiatric Consult (must be referred by Primary Care)

Select : ☐ Consultation

☐ Medication recommendation

☐ Diagnosis

Billing Number: _____

Additional details for requested services

Additional Information and Referral Attachments

Additional information attached or to follow: ○Yes ◉No

☐Diagnosis note ☐ Assessment note ☐ Medications ☐ Other: _____

Any current medical concerns? ○Yes ○ No ◉ Unknown Details: _____

Currently taking any medications? ○Yes ○No ◉Unknown Details: _____

Any current legal issues? ○Yes ○No ◉Unknown Details: _____

Person referred has a history of aggressive behavior? ○Yes ○No ◉Unknown Details: _____

For referred agency use only

Date/time referral received: _____ Date/time client assessed: _____

Date/time client on service: _____

☐

This form contains personal health information that is subject to the provisions of the *Personal Health Information Protection Act.* The information is collected for the purpose of referring patients to local mental health and addictions agencies which offer services that may benefit them. Mental Health and Addictions agencies will only use the information to assess patient eligibility and arrange services as required.