

## 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): \_\_\_\_\_ 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: \_\_\_\_\_ ext.: \_\_\_\_\_ Alternate Telephone: \_\_\_\_\_ ext.: \_\_\_\_\_  No known telephone

Language first spoken:  English  French  Other (specify): \_\_\_\_\_

In which of language is person being referred most comfortable?  English  French  Other

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

If yes, name of Psychiatrist: \_\_\_\_\_  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

Telephone \_\_\_\_\_ ext.: \_\_\_\_\_  Unknown Fax #: \_\_\_\_\_  Unknown

**Requested Services – Check all that apply**

**Reason for Referral(s):** \_\_\_\_\_

**Mental Health**

- Child and Youth
- Seniors Mental Health
- Family
- Legal / Court
- Sexual Assault / Domestic Violence
- Peer Support
- Housing
- Social / Rehabilitation Support
- Concurrent Disorder
- Case Management
- Dual Diagnosis
- Eating Disorder
- Early Psychosis
- Other (please specify in details section below)

**Addictions or Substance Abuse**

- Child and Youth
- Family
- Assessment
- Withdrawal Management
- Outpatient Treatment
- Residential Treatment
- Supportive Housing
- Alcohol
- Drugs
- Opiates
- Gambling
- Case Management
- Other (please specify in details section below)

**Psychiatric Consult (physician or NP referral only)** Billing # \_\_\_\_\_

- Consultation/Assessment
- Diagnosis
- Medication Management

Additional Details: \_\_\_\_\_

**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: \_\_\_\_\_

Pregnant or recent childbirth? Yes No Unknown Details: \_\_\_\_\_

Currently on medication(s)? Yes No Unknown Details: \_\_\_\_\_

Any current legal issues? Yes No Unknown Details: \_\_\_\_\_

**History of aggressive behavior?** Yes No Unknown **Details:** \_\_\_\_\_

**For receiving agency use only**

Date/time referral received: \_\_\_\_\_ Date/time client assessed: \_\_\_\_\_

Date/time client on service: \_\_\_\_\_

North East Ontario

**North East Connect Referral Contact Information**

**Service Referral Information:**

[Sault Area Hospital - Mental Health and Addictions - Eating Disorder Program](#)

750 Great Northern Rd, Sault Ste Marie, ON, P6B 0A8

**Referral Contact:**

Staff on Duty, Intake Worker

Phone: 705-759-3434 ext 4627

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