

## 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:**

[West Nipissing General Hospital - Sturgeon Falls - Alliance Centre - Needle Exchange Program](#)

172 Ethel St, Sturgeon Falls, ON, P2B 1V9

**Referral Contact:**

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