

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:

[Family Care Pharmacy - Iroquois Falls - Opioid Use Disorder Program](#)

125 Ambridge Dr, Iroquois Falls, ON, P0K 1G0

Referral Contact:
