

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:

[Canadian Mental Health Association \(CMHA\) Cochrane Timiskaming Branch - Treatment For Women Survivors Of Sexual Abuse - Iroquois Falls](#)

A-58 Anson Dr, Iroquois Falls, ON, P0K 1G0

Referral Contact:
