Ontario
North East Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Est

North East CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires du Nord-Est

ConnexOntario
Health Services Information
Information sur les services de santé

thehealthline.ca

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.

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.

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: _____

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North East Ontario

North East Connect Referral Contact Information

Service Referral Information:
Canadian Mental Health Association (CMHA) Cochrane Timiskaming Branch - Regional Early Intervention Program - Iroquois Falls
A-58 Anson Dr, Iroquois Falls, ON, P0K 1G0
Referral Contact: