

PLEASE NOTE: INCOMPLETE FORMS WILL CAUSE DELAY



**Canadian Mental
Health Association**
Elgin County

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REFERRAL FORM

CLIENT INFORMATION

Date of Referral: mm/dd/yyyy	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other:	
Name:	D.O.B.: mm/dd/yyyy	HSC RAN#:
Address:	City:	PC:
Phone:	Alt Phone:	
Source of Income:	Email:	

REQUESTED SERVICES

<input type="radio"/> Brief Counselling	<input type="radio"/> Case Management	<input type="radio"/> Court Support
<input type="radio"/> Early Psychosis (PEPP)	<input type="radio"/> Groups	<input type="radio"/> Housing
<input type="radio"/> Psychiatric Consultation	<input type="radio"/> SKILLS (Vocational Program)	<input type="radio"/> Support Within Housing
<input type="radio"/> Therapeutic Recreation	<input type="radio"/> Other:	

Diagnosis:

Concurrent/Dual Diagnosis: Substance Abuse: _____
 Learning Disability: _____
 Developmental Disability: _____

No known diagnosis

REFERRAL SOURCE

Name:	Email:	
Agency:	Ph:	Fax:
Address:	City:	PC:

BRIEF DESCRIPTION OF REASONS FOR REFERRAL & PRESENTING ISSUES:

C.M.H.A., Elgin Referral Form (continued)	
Patient Name:	D.O.B.: mm/dd/yyyy
Current Service Providers & Supports (i.e. psychiatrist, ADSTV, VAWSEC, EAP, STEGH, Probation/Legal etc.)	
Family Physician:	<input type="radio"/> See Attached OCAN
Psychiatric History & Treatment (where, when, duration, outcome)	
Risk Factors:	
<input type="checkbox"/> suicidal ideation/recent attempt or intentional self harm behaviour	
<input type="checkbox"/> homicidal ideation/violence/aggression towards others	
<input type="checkbox"/> domestic violence	
<input type="checkbox"/> other:	
Current Medication(s):	<input type="radio"/> See Attached Medication List
Physical Health/Significant Medical History:	
Please attach any additional information that you feel is important to facilitate referral	
<input type="radio"/> Requesting confirmation of receipt	<input type="radio"/> Client in agreement with referral
<input type="radio"/> Requesting notification of initial appointment date/outcome	