REFERRAL FORM

ADDICTION & MENTAL HEALTH SERVICES

***Incomplete forms will be returned**
***If you consider this to be urgent, please follow up with a phone call**

Date of Referral: ______________________________ Referred by: ______________________________

Agency: ______________________________ Phone #: ______________________________

Last Name: ______________________________ Medicare #: ______________________________

First Name: ______________________________ D.O.B.: __ __ __ __/__ __/__ __ (Y/M/D)

Maiden/Other Name: ______________________________ Gender: ☐ Female ☐ Male ☐ X ☐ Other

Other contact person: ______________________________ Can a message be left?: ☐ Yes ☐ No

Address: ______________________________ Language:☐English ☐French ☐ Other:________

City/Prov: ______________________________ Postal Code: ______________________________

Home Phone #: ______________________________ Cell Phone #: ______________________________

Who to contact for appointment: ____________________ Phone #: ______________________________

Family Doctor: ______________________________ Pharmacy: ______________________________

Employee Assistance Plan: ☐☐ Yes ☐☐ No Willing to access: ☐ ☐Yes ☐☐ No

REASONS FOR REFERRAL: How can we help? (Please be as specific as possible with your requests)

____

____

____

____

____

____

Suicidal: ☐ Yes ☐ No ☐ Did not assess

Harm to self or others: ☐ Yes ☐ No ☐ Did not assess

MEDICATIONS:

____

____

Is client aware of referral: ☐ Yes ☐ No

SERVICES FOR: ☐ MENTAL HEALTH ☐ ADDICTION

Client will be contacted directly unless otherwise indicated

Draft Copy September 16, 2020