1 844 437 3247
(HERE247)

Call anytime to access
Addictions, Mental Health
& Crisis Services
Waterloo-Wellington

A – Demographics of Person Seeking Service *(Attach label here if available)*

First Name: ____________________ Address: ____________________

Last Name: ____________________ ____________________

Gender: ____________________ City: ____________________

DOB: ____________________ Postal Code: ____________________
dd mm yyyy

Phone: ____________________ Ok to leave message: ❑ Yes ❑ No

Preferred Language: ❑ EN ❑ FR ❑ Other (Specify): ____________

REFERRAL FORM

Family Physician: ________________________________ HC #: ____________________ Version Code: ________

Living Situation: ❑ Alone ❑ With Spouse/Family ❑ Supportive Housing ❑ Shelter ❑ Foster Home ❑ Residence

❑ Other (Specify): ____

Is person aware of referral?: ❑ Yes ❑ No

B – Guardian/Custody Status *(if applicable)*

Custody Status: ❑ Lives with both parents ❑ Joint Custody ❑ Sole Custody ❑ Lives Independently

❑ Other: ____

1. Guardian Name: ________________________________ Phone: ____________________

2. Guardian Name: ________________________________ Phone: ____________________

C – Alternate/Emergency Contact Person

Name: ________________________________ Phone: ____________________

Relationship to Person: ________________________________ Alt. Phone: ____________________

Address: ____

Conduct call back with: ❑ Person Seeking Service ❑ Guardian ❑ Alternate/Emergency Contact ❑ Referrer (see below)

D – Referrer Contact Information

Referrer Role: ❑ Family Physician ❑ Nurse Practitioner ❑ ER Physician ❑ Other (Specify):____________________

Name: ________________________________ Phone: ____________________

Organization: ________________________________ Fax: ____________________

Follow-up with me via: ❑ Phone/Voice Mail ❑ Fax ❑ None OHIP Billing #: ____________________

E – Reason for Referral

Reason for Referral: *(i.e. consultation, goals for assessment, treatment, etc.)*

Why are you referring the person now? *(i.e. current symptoms, presenting problems, history, etc.)*

Substance Use: (current substances, amount, frequency of use, etc.) Does the person want help with this issue? ❑ Yes ❑ No

F – Services Requested *(copy from brochure)*

If someone is in crisis, please call 1-844-HERE-247 (437-3247) IMMEDIATELY

❑ Information, Assessment and Referral
❑ Community Counselling and Treatment
❑ Support Within Housing
❑ Eating Disorders
❑ Support Coordination
❑ Peer/Self-Help
❑ Day/Evening Treatment
❑ Early Psychosis
❑ Short-Term Crisis Support Beds
❑ Diversion and Court Support
❑ Assertive Community Treatment Team
❑ Residential Treatment

Call Back Date and Time *(Copy from brochure)*

Date: ______________________ (dd mm yyyy)

Time: ❑ 8:30-10:00AM ❑ 10:00AM-12:00PM ❑ 12:00-2:00PM ❑ 2:00-4:00PM ❑ 4:00-6:00PM ❑ 6:00-8:00PM

G – Risk Issues

Risk Issue	Check	If yes, when?	Details
Suicide Attempt/Ideation	❑ Yes ❑ No		
Deliberate Self-Harm	❑ Yes ❑ No		
Homicidal Threats/Ideation	❑ Yes ❑ No		
Violent Behaviour	❑ Yes ❑ No		
Legal Involvement	❑ Yes ❑ No		
Fire Setting	❑ Yes ❑ No		

H – Medications *(psychiatric and non-psychiatric – attach additional information if needed)*

Medications	Current	Past	Dose/Frequency	Response and Adverse Effects
	❑	❑		
	❑	❑		
	❑	❑		
	❑	❑		

I – Relevant History & Existing Supports

Past History of Mental Health and Addictions: *(i.e. date of onset, diagnosis, treatments, admissions)*

Relevant Medical or Developmental History: *(i.e. disabilities, intellectual delay, autism, allergies, endocrine, neurological respiratory, cardiac, metabolic or other issues)*

Other Supports Involved: *(i.e. agencies, hospitals, treatment providers, community supports)*

Completed by: ______________________________ (print name and credentials)

Signature: ______________________________

Date: ______________________ (dd mm yyyy)

FAX TO: 1-844-HERE-FAX
(437-3329)