HERE 24/7 Referral Form

PRIVATE AND CONFIDENTIAL

1 844 437 3247 (HERE247)
Call anytime to access Addictions, Mental Health & Crisis Services
Waterloo-Wellington

Date: Click here to enter date	**Name of individual:** Last, First	**Date of Birth:**

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

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

Client

Preferred name:

Gender **Preferred language:**

Address:

City: **Postal code:**

Home phone: **Cell phone:** ☐ **Ok to leave a message**

Email: **Best time to reach client:**

B. Referral

Family physician: **Health card #:** **Version code:**

Living situation: Choose an item. **Other** (specify):

Is person aware of referral? ☐ **Yes** ☐ **No**

C. Guardian/Custody Status *(if applicable)*

Custody Status: Choose an item. **Other:**

Guardian Name: **Phone:**

Guardian Name: **Phone:**

D. Alternate/Emergency Contact Person

Name:

Home phone: **Cell phone:** ☐ **Ok to leave a message**

Email: **Best time to reach contact:**

Relationship: **Conduct call back with:** Choose an item.

E. Referrer Contact Information

Referrer role: Choose an item. **If other, specify:**

Name: **Phone:**

Organization: **Fax:**

Follow up via: ☐ **Phone/ voicemail** ☐ **Fax** ☐ **None** **OHIP billing #:**

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

Please note: If the service(s) you are referring to do not exist within CMHAWW, we will reach out to the client and provide external resources

What specific services are you requesting? Services with 🚩 icon require their own referral forms – incomplete forms will be returned

- ☐ Psychiatry 🚩
- ☐ Eating Disorders (Child & Adolescent) 🚩
- ☐ Diversion and Court Support (Mental Health & Justice)
- ☐ Community Counselling and Treatment
- ☐ Peer/ Self Help
- ☐ Residential Addictions Treatment
- ☐ Mental Health/Addictions Support Within Housing
- ☐ Day/ Evening Addictions Treatment
- ☐ Dialectical Behaviour Therapy (DBT) 🚩
- ☐ Eating Disorders (Adults)
- ☐ Early Psychosis 🚩
- ☐ Adult Intensive Services (AIS)

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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**

G. Risk Issues

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

H. Psychiatric or non psychiatric medication or attach medication list – if available

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: **Position:**

CC:
Client Family: **Date:**
Referral Source/GP: **Date:**
Other: **Date:**

****Once completed please fax to 1-844-HERE-FAX (844-437-3329)**
Any Questions Please Contact us anytime at 1 844 437 3247 (HERE247) or TTY: 1-877-688-5501