| 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* |
| 1. 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: |       |
| 1. Referral
 |
| Family physician: |       | Health card #: |       | Version code: |       |
| Living situation: | Choose an item. | Other (specify): |       |
| Is person aware of referral? |[ ]  Yes |[ ]  No |
| 1. Guardian/Custody Status *(if applicable)*
 |
| Custody Status: | Choose an item. | Other: |       |
| Guardian Name: |       | Phone: |       |
| Guardian Name: |       | Phone: |       |
| 1. 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. |
| 1. Referrer Contact Information
 |
| Referrer role: | Choose an item. | If other, specify: |       |
| Name: |       | Phone: |       |
| Organization: |       | Fax: |       |
| Follow up via: |[ ]  Phone/ voicemail |[ ]  Fax |[ ]  None | OHIP billing #: |       |
| 1. 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  |[ ]  Flag with solid fillEating Disorders (Child & Adolescent)  |[ ]  Diversion and Court Support (Mental Health & Justice)  |
|[ ]  Flag with solid fillCommunity Counselling and Treatment |[ ]  Flag with solid fillPeer/ Self Help |[ ]  Residential Addictions Treatment |
|[ ]  Mental Health/Addictions Support Within Housing  |[ ]  Day/ Evening Addictions Treatment | [ ]  | Flag with solid fillDialectical Behaviour Therapy (DBT)  |
|[ ]  Eating Disorders (Adults) |[ ]  Flag with solid fillEarly Psychosis  |[ ]  Adult Intensive Services (AIS) |
| 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 |
| 1. 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 |       |       |
| 1. Psychiatric or non psychiatric medication or attach medication list – if available
 |
| Medications | Current | Past | Dose/Frequency | Response and Adverse Effects |
|       |[ ] [ ]        |       |
|       |[ ] [ ]        |       |
|       |[ ] [ ]        |       |
|       |[ ] [ ]        |       |
|       |[ ] [ ]        |       |
| 1. 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