| 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 | | | | |
|  | | | | | | | | |  | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | |  | | | | |
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|  | | | | | | | | |  | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | |  | | | | |
| 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