REFERRAL FORM – CLIENT SERVICES
District Mental Health Services for Older Adults Program

P.O. Box 1317
Northwestern Health Unit - 115 Main Street
Atikokan, Ontario P0T 1C0
Phone: (807) 597-2015
Fax: (807) 597-6170

Please mail/fax to the above location. For more information about services offered by CMHA please contact us or visit our website at www.fortfrances.cmha.ca

First: ____________________ Middle: __________________ Last Name:____________________________

☐ Male ☐ Female ☐ Other Date of Birth: _______________ Health Card: ____________________

Address: ____

Postal Code: ________________________________ Telephone: ______________________________

Directions to home: ____

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Mental Health Diagnosis: ____

Reason For Referral:

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Is the client/substitute decision maker (SDM) aware and consenting to the referral? ☐Yes ☐ No

If the answer is no, the referral source will be contacted for additional information.

Referral Source: ____

Date of Referral: _____________________________ Telephone: ______________________________

(2022/04)

Presenting Information:

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Marital Status: ______________________________ Spouse's Name: _________________________

Primary Caregiver: __________________________ Relationship to Client: ___________________
(if different from spouse)

Telephone: _________________________________

Client's Physician: ____________________________ Telephone: ____________________________

Has this client seen a psychiatrist: ☐Yes ☐No Name: ________________________________

Current Medication:

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Any Other Medical Issues/Allergies:

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History of Hospitalizations/Emergency Department Visits in the Past 2 Years:

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Additional Information that may be helpful in our service delivery:

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Completed by: _________________________________ Phone Number: _____________________