REFERRAL FORM – CLIENT SERVICES

P.O. Box 446 – 612 Portage Avenue
Fort Frances, Ontario P9A 3M8
Phone: (807) 274-2347
Fax: (807) 274-3515

Please indicate the CMHA services to which you are making the referral and 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

☐ **District Mental Health Services for Older Adults Program**

☐ **Community Support Team**
- **Case Management**
- **Court Diversion & Support**
- **Housing Supports**

☐ **District Peer Support Program**
- **Peer Support**
- **Family Support**
- **Peer Support Drop-In Centre**

First: ____________________ Middle: _________________ Last Name:___________________________

☐ Male ☐ Female ☐ Other Date of Birth: ______________ Health Card: ___________________

Address: ____

Postal Code: ______________________________ Telephone: _____________________________

Directions to home: ____

____

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: _____________________________

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: ______________________