Canadian Mental Health Association
Fort Frances Branch
Mental health for all

REFERRAL FORM – CLIENT SERVICES

P.O. Box 492 – 21 Wolsley Street
St. Joseph's Health Centre
Kenora, Ontario P9N 3X5
Phone: (807) 468-4699
Fax: (807) 468-7628

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 the Older Adults Program**

☐ **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:

_____

_____

_____

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:

_____

_____

_____

_____

_____

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:

_____

_____

_____

_____

_____

Any Other Medical Issues/Allergies:

_____

_____

_____

_____

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

_____

_____

_____

Additional Information that may be helpful in our service delivery:

_____

_____

_____

_____

_____

Completed by: _____ Phone Number: _____