Addiction Services
of Thames Valley | Services de toxicomanie de Thames Valley

French Mental Health and Addictions System Navigation Program
REFERRAL FORM

The following referral form is intended for an agency / organization or self referred individuals to the French Mental Health and Addictions System Navigation Program. Once completed, **please fax to (519) 673-1022,** or mail it at **260-200 Queens 'Ave, London, ON. N6J 1J3**

Internal ADSTV Referral (Open File)? ☐ Yes ☐ No *if* Yes, *please only complete areas with* *****

We are here to help. How can we help you?

_____

_____

_____

_____

*** NAME:** _____ *__D.O.B.__ (d/m/y): _____

LAST NAME at BIRTH: _____

Client Canadian Born ☐ Yes ☐ No

Date of Arriving in Canada_____

GENDER: ☐ Male ☐ Female ☐ Other

Email address:_____

Okay to email? ☐ Yes ☐ No

DOES THE CLIENT HAVE

A FIXED ADDRESS? ☐ Yes ☐ No

STREET: _____

APT/UNIT: _____

CITY: _____

HOME PHONE: ( ) _____
Okay to call? ☐ Yes ☐ No
Leave message? ☐ Yes ☐ No

OTHER PHONE: ( ) _____
Okay to call? ☐ Yes ☐ No
Leave message? ☐ Yes ☐ No

Person Responsible of the Client's Care /Next of Kin Guardian/Substitute Decision Maker:

Parent's /Guardian Names (if under 12): _____

Address (if different from client):

_____

Phone Number:_____

Email address:_____

Okay to email? ☐ Yes ☐ No

*** PRESENTING PROBLEM/CONCERN (Check all that apply):**

☐ Mental Health Concerns

☐ Addiction concerns

☐ Gambling Problems

☐ Gaming Problems

French Mental Health and Addictions System Navigation Program
REFERRAL FORM

POSTAL CODE: _____

*** For Crisis Support:**

Presenting concern: _____

*** Medical Conditions/ History:**

_____

(Currently have a GP/Family Doctor? ☐ Yes ☐ No)

*** Psychiatric Diagnosis:**

_____

(Currently have a Psychiatrist? ☐ Yes ☐ No)

REFERRING AGENCY ONLY:

_____

*** CONTACT**: _____ **PHONE**: ( ) _____ **EXT**: _____

FAX: ( )_____ **EMAIL**: _____

OTN EQUIPMENT AVAILABLE AT REFERRING SITE? ☐ Yes ☐ No

(IF Yes, Site#_____ System #_____

I WOULD LIKE TO RECEIVE FEEDBACK REGARDING CLIENT'S INVOLVEMENT WITH ADSTV
(To receive feedback, the client must sign the *Consent for Release of Information* and/ or *Consent to the Collection, Use and Disclosure of Personal Health Information*) ☐ Yes ☐ No

CONTACT *Please choose one of the following:*

☐ Please contact me (referring agency) **BEFORE** contacting client.

☐ Upon receiving referral, please contact client directly.

FOR OFFICE USE ONLY

DATE RECEIVED:	CONTACTED? ☐ Yes ☐ No	INITIALS:
INTAKE COMPLETED? ☐ Yes ☐ No	INTAKE DATE? ☐ Yes ☐ No	INITIALS:
ELIGIBLE? ☐ Yes ☐ No	APPOINTMENT BOOKED? ☐ Yes ☐ No	INITIALS:

SIGNATURE: _____ **DATE**: _____

FOR OFFICE USE ONLY

DATE RECEIVED:	CONTACTED? ☐ Yes ☐ No	INITIALS:
INTAKE COMPLETED? ☐ Yes ☐ No	INTAKE DATE? ☐ Yes ☐ No	INITIALS:
ELIGIBLE? ☐ Yes ☐ No	APPOINTMENT BOOKED? ☐ Yes ☐ No	INITIALS: