PLEASE NOTE: INCOMPLETE FORMS WILL CAUSE DELAY

Canadian Mental Health Association
Elgin County

110 Centre Street
St. Thomas, ON
N5R 2Z9
Tel: (519) 633-1781
Fax: (519) 631-8273
admin@cmhaelgin.ca
www.cmhaelgin.ca

REFERRAL FORM

CLIENT INFORMATION

Date of Referral: mm/dd/yyyy	◯ Male ◯ Female ◯ Other:	
Name:	D.O.B.: mm/dd/yyyy	HSC RAN#:
Address:	City:	PC:
Phone:	Alt Phone:	
Source of Income:	Email:	

REQUESTED SERVICES

◯ Brief Counselling	◯ Case Management	◯ Court Support
◯ Early Psychosis (PEPP)	◯ Groups	◯ Housing
◯ Psychiatric Consultation	◯ SKILLS (Vocational Program)	◯ Support Within Housing
◯ Therapeutic Recreation	◯ Other:	

Diagnosis:

Concurrent/Dual Diagnosis:
◯ Substance Abuse: _____
◯ Learning Disability: _____
◯ Developmental Disability: _____

◯ No known diagnosis

REFERRAL SOURCE

Name:	Email:	
Agency:	Ph:	Fax:
Address:	City:	PC:
BRIEF DESCRIPTION OF REASONS FOR REFERRAL & PRESENTING ISSUES:		

C.M.H.A., Elgin Referral Form (continued)	
Patient Name:	D.O.B.: mm/dd/yyyy
Current Service Providers & Supports (i.e. psychiatrist, ADSTV, VAWSEC, EAP, STEGH, Probation/Legal etc.	
Family Physician:	◯ See Attached OCAN
Psychiatric History & Treatment (where, when, duration, outcome)	
Risk Factors:	
□ suicidal ideation/recent attempt or intentional self harm behaviour	
□ homicidal ideation/violence/aggression towards others	
□ domestic violence	
□ other:	
Current Medication(s):	◯ See Attached Medication List
Physical Health/Significant Medical History:	
Please attach any additional information that you feel is important to facilitate referral	
◯ Requesting confirmation of receipt	◯ Client in agreement with referral
◯ Requesting notification of initial appointment date/outcome	