Health Sciences North
Horizon Santé-Nord

Sudbury Mental Health and Addictions Centre
Centre de santé mentale et de toxicomanie de Sudbury
127 Cedar Street, Sudbury Ontario P3E 1B1
T (705)523-4988 F (705) 523 7322

Date:

~PLEASE COMPLETE ALL SECTIONS OF THIS REFERRAL~

Client/Patient Information

Name: _____

Health Card # _____ - _____

Date of Birth: _____ / ____ / ____ (d/m/yy) **Age**: _____

Sex: ☐M ☐F ☐Transgendered

Address:_____

City: _____ **Postal Code**: _____

Contact: Home: _____
Office: _____
Cell: _____

Can a letter be sent to the above address
☐ Yes ☐ No

Can a confidential message be left on voicemail?
☐ Yes ☐ No

Is client/patient aware and agreeable to referral?
☐ Yes ☐ No

Referring Source Information

Check One: ☐ Family Physician
☐ Nurse Practitioner
☐ Psychiatrist
☐ Other (specify) _____

Referral Source: _____

Address:_____

City: _____ **Postal Code**: _____

Contact: Tel: _____
Fax: _____
Other: _____

Name of person completing form: _____

Name of family physician: _____

If client is unable to make a decisions for themselves please indicate who to contact:

Name:_____ Tel: _____

REASONS FOR REFERRAL: (Please send any additional information including medication list if available)

_____

_____

_____

_____

PROGRAM/SERVICE REQUEST:

☐ Perinatal Program (EPDS Score: ___)
☐ Early Psychosis Intervention
☐ Gambling Services
☐ Mood and Anxiety Program
☐ Outpatient Addictions
☐ Eating Disorders Program
☐ Senior's Mental Health Outreach Program **(long term care facilities require Physician referral)**
☐ Psychiatric Consultation **(Requires referral from Physician/Nurse Practitioner)** _____ **Billing # required**

Name of current psychiatrist: _____

FOR OFFICE USE ONLY (CDS requirements): **SH**: _____

☐ **Language spoken** _____ ☐ **Highest Level of Education** _____

☐ **Status/Aboriginal** _____ ☐ **OW/ODSP recipient**_____