Canadian Mental Health Association
Association canadienne pour la santé mentale
Cochrane-Timiskaming

South Timiskaming sud
Box 249/C.P. 249,
20 rue May Sud / 20 May Street South
Temiskaming Shores, ON P0J 1P0
Tel/tél: 705.647.4444
Fax/téléc: 705.647.4434

CLIENT REFERRAL

Office Use Only:
Date Rec'd: ***Worker Initials:***

☐ **Mental Health** ☐ **Addictions** ☐ **Concurrent Disorders**
☐ **Education** ☐ **Groups/Workshops**

GENERAL INFORMATION

DEMOGRAPHICS	
First Name:	**Last Name:**
Middle Name:	**Gender:** ☐ Male ☐ Female ☐ Other:
D.O.B. (mm/dd/yy):	**Ontario Health Card?:** ☐ Yes ☐ No
Street & No.:	**Town:**
Province:	**Postal Code:**
Home Phone: *Permission to leave message*? ☐ Yes ☐ No	**Cell Phone:** *Permission to leave message*? ☐ Yes ☐ No
Alternate Phone: *Permission to leave message*? ☐ Yes ☐ No	**Email:**
Preferred Language: ☐ English ☐ French ☐ Bilingual ☐ Other:	
Do you have any accessibility needs and/or requirements? ☐Yes ☐ No Please specify: _____ ☐ Allergies: _____ ☐ Other(s): _____	

REFERRAL AGENCY	
Name of Agency: Temiskaming Hospital	**Phone:**
Name of person referring:	**Fax:**
Address:	**Email:**

MENTAL HEALTH & ADDICTIONS

PRESENTING ISSUES			
ADDICTIONS	**MENTAL HEALTH**	**DAILY LIFE STRUGGLES**	
☐ Alcohol	☐ Symptoms of Mental Illness	☐ Financial	☐ Problems with relationships
☐ Drugs	☐ Anger/Aggression/Violence by Self	☐ Legal	☐ Child Welfare
☐ Alcohol + Drugs	☐ Eating Disorder	☐ Employment	☐ Learning/Cognitive Issues
☐ Tobacco	☐ Emotional Abuse	☐ Educational	
☐ Gambling	☐ Sexual Abuse	☐ Financial	
	☐ Attempted Suicide	☐ Housing	
		☐ Legal	

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CLIENT REFERRAL

Do you have a mental health diagnosis (formal or informal)? x☐Yes ☐ No ☐ Declined ☐ Unknown

Please specify diagnosis: _____

Mental Health Diagnostic Categories by Doctor or Psychiatrist (select all that apply)	
☐ Adjustment disorders/stress	☐ Personality disorders
☐ Anxiety disorder	☐ Schizophrenia & other psychotic disorders
☐ Delirium, dementia, and cognitive disorders	☐ Sexual and gender identity disorders
☐ Developmental handicap (i.e. autism)	☐ Sleep disorders
☐ Disorder of childhood/adolescence	☐ Somatoform disorders/pain
☐ Dissociative disorder	☐ Substance related disorders/addiction
☐ Eating disorder	☐ Intellectual disability or impairment
☐ Factitious disorder	☐ Brain Injury
☐ Impulse control disorders (i.e. gambling, kleptomania)	☐ Dual Diagnosis (Developmental & Mental illness)
☐ Mental disorders due to medical conditions (i.e. Brain Injury)	
☐ Mood disorder (i.e. Depression, Bipolar, PTSD)	

What has prompted this referral? *(Mental health concerns, situational factors, legal, behaviours, hallucinations, etc.)*

Are there any risk factors?*(Current and historic; suicidal, homicidal, self-neglect, harmful environment, risk assessments, etc.)*

Additional information*: (optional)*

CLIENT REFERRAL CONSENT:

CMHA requires a signed consent by client in order to discuss this referral.

Client is required to call CMHA at (705) 647-4444 and speak with an Access worker in order to express interest for services.

I, _____ (client name) hereby authorize _____ (referral agency) and **CMHA-CT** to exchange information regarding this referral process, case management and any other information to assist in service delivery.

Witness Signature:	**Client Signature:**
Date:	**Date:**