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

TEMISKAMING HOSPITAL

CLIENT REFERRAL

GENERAL INFORMATION

DEMOGRAPHICS	
First Name:	
Last Name:	
D.O.B. (mm/dd/yy):	
Gender: ☐ Male ☐ Female ☐ Other:	
ADDRESS:	
CITY: **Postal Code:**	***CHART LABEL (optional)***

Contact #1: *Permission to leave message*? ☐ Yes ☐ No	**Contact #2:** *Permission to leave message*? ☐ Yes ☐ No
Preferred Language: ☐ English ☐ French ☐ Bilingual ☐ Other:	

Reason for the referral?
(Mental health concerns, situational factors, legal, behaviours, hallucinations, PPMD, addictions, etc.)

Please forward client's discharge summary with this referral.

Fax: 705-647-4434

CLIENT REFERRAL CONSENT:

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

Client or referring agency is required to call CMHA at (705) 647-4444 and speak with an Access worker in order to express interest for services and/or discuss the client's needs.

I, _____ (client name) hereby authorize the **Temiskaming Hospital** 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:**