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

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 Temiskaming Hospital (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: Tania Osborne	**Client Signature:** Verbal consent given
Date:	**Date:**