ROT09

REFERRAL FORM (for professionals)

Mental Health & Addiction Regional Centre
Crisis Team ◆ Mental Health Treatment Service ◆ Addiction Service
◆ ACTT ◆ Geriatric Psychiatry Service
580 Spence St, Hawkesbury, On K6A 0B4
1-844-304-1414 / Fax: (613) 632-7450

Sticker
(for MH+A use only)

REFERRAL SOURCE

Agency / Source:_____ Contact name:_____

Telephone:_____ Fax:_____

Date of Referral (yyyy/mm/dd):_____

Is the referral mandated by (if applicable):

☐N/A ☐Probation Condition/Court Ordered ☐Children's Aid

CLIENT INFORMATION

Name:_____ Date of Birth (yyyy/mm/dd):_____

Address:_____

City:_____ Postal Code:_____

Identification of first language: English___ French___ Other:_____

Preferred Contact #:_____ Can message be left at this number? ☐Yes ☐No

Alternate Contact #:_____ Can message be left at this number? ☐Yes ☐No

Family Physician / Psychiatrist: (if different from referrer)_____

Health Card #:_____ V-Code:_____ Exp. Date (yy/mm):_____

Contact person for the first appointment or for emergency: _____

Relationship to client: _____ Power of Attorney? ___Yes ___No

Telephone Number: _____ Alternate: _____

SERVICES REQUESTED

☐ Mental Health Services *(for individuals aged 16 and over)* ☐ Addictions Services *(for individuals aged 12 and over)* ☐ Both services

Please specify the type of service requested:

_____

_____

_____

_____

_____

INFORMATION REGARDING CLIENT'S SITUATION

Risk Factors:

- Harm to Self / Suicidal ☐Yes ☐No Comment: _____
- Harm to Others / Homicidal ☐Yes ☐No Comment: _____
- Social Isolation ☐Yes ☐No Comment: _____
- Current Legal Issues ☐Yes ☐No Comment: _____
- Running away / Wandering ☐Yes ☐No Comment: _____
- Risk of abuse / Safety concerns ☐Yes ☐No Comment: _____
- Decreased Functionality ☐Yes ☐No Comment: _____
  (self-care, finances, housing, medication mismanagement)

- Other:_____ Comment: _____

Please provide any relevant information regarding your client's situation (i.e. events, stressors, substance use):

_____

_____

_____

Symptomatology / Medical Status (diagnosis, medication):

_____

_____

_____

CONSENT

Has the client been informed of this request for service? ☐Yes ☐No

TREATING FAMILY PHYSICIAN

Name of family doctor (please print): _____ Billing #: _____

_____ _____

Signature Date