HGH
COMPASSION INNOVATION EXCELLENCE

ROT09

REFERRAL FORM (FOR SELF-REFERRAL)

Mental Health & Addiction Regional Centre
Crisis Team ◆ Mental Health Treatment Program ◆ Addiction Program ◆ ACTT ◆ Geriatric Psychiatry Program

580 Spence St, Hawkesbury, On K6A 0B4
1-844-304-1414 / Fax: (613) 632-7450

CLIENT INFORMATION

Name:____ Date of Birth *(yyyy/mm/dd)*:__________________________

Address:____

City:______________________________________ Province: ____________ 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: ____

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 INFORMATION

❐ Mental Health Services *(for individuals aged 16 and over)* ❐ Addictions Service *(for individuals aged 12 and over)* ❐ Both

Please provide additional specific information regarding your request for services:

____
____
____

Is the referral mandated by: ☐N/A ☐Children's Aid ☐Probation Condition/Court Ordered

IMPORTANT INFORMATION REGARDING YOUR SITUATION

Risk Factors

- ◆Are you at risk to harm yourself? Are you suicidal? ☐Yes ☐No
- ◆Are you at risk to harm others or commit a homicide? ☐Yes ☐No
- ◆Do you feel socially isolated? ☐Yes ☐No
- ◆Do you currently have legal issues? ☐Yes ☐No
- ◆Are you currently victim of violence? ☐Yes ☐No

Is there any additional information you would like to let us know about?

____
____
____

________________________________ ________________________
Signature Date

❐ Completed by secretary, telephone request Name of secretary: ____________________

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