 **Canadian Mental Health Association, Haliburton, Kawartha, Pine Ridge Branch**

 **Referral Form**

**Instructions: Please complete all fields to the best of your ability. If you require assistance completing this form, please call or ask someone at reception.**

**Please be advised that there may be a wait time for your initial intake appointment.**

**If you are in need of immediate assistance, please call Four County Crisis at 866-995-9933.**

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| **Today’s Date:** | **Name:****Date of Birth:** | **Address:** | **Gender:****[ ] Male [ ]  Trans** **[ ] Female [ ] Other****[ ] Choose not to disclose** | **Telephone:****or****Cell:****or** **E-mail:** | **Can we leave a message?****[ ] Yes** **[ ] No** |
| **What is your** **preferred language:** | **Are you of Aboriginal descent?** **[ ] Yes [ ] No** | **Canadian Citizen****[ ] Yes [ ] No** | **Health card number** **and version code:** | **What is your mental health** **diagnosis?** |
| **Addictions?****[ ] Yes [ ] No** | **What is your source of income?** | **Are you currently:****[ ] In school** **[ ] Working****[ ] None** | **What is your highest level of education you have completed?****[ ]  Elementary** **[ ]  Some high school** **[ ]  High School** **[ ]  Some College** **[ ]  College/University** |
| **Are you requesting a** **Psychiatrist?** **[ ] Yes [ ] No** | **Have you ever accessed Four County Crisis Services?** **[ ] Yes [ ] No** | **What type of residence do you live in?** **e.g. home, apartment, shelter, hospital** | **Who do you live with?** |
| **PLEASE DESCRIBE PRESENTING CONCERNS:** |
| **Is the client aware of this referral? [ ] Yes [ ] No Please note that we may need to contact the referral source for further information** |
| **Referral source:** **Agency: Name: Contact information:** |
| **Office Use Only** |
| **Initial contact date:** | **Message left: [ ] Yes [ ] No****Staff:** | **Appointment booked:** **Date: Time:** | **Entered into CRMS:****[ ] Yes [ ] No** |
| **Remarks:** |

 **5/19**