 **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**