Canadian Mental Health Association
Haliburton, Kawartha, Pine Ridge
Mental health for all

ADMISSION CRITERIA

1. Ages 16 -24 years of age
2. Identified mental health, addiction, developmental and /or acquired brain injury
3. Demonstrate the need for increased IL skill building

The referral form must be completed and faxed to CMHA HKPR
The referral source will receive notification of a follow-up screening date
The client will be required to meet with the co-facilitators and complete a brief questionnaire.
Subsequent to the screening, the client and worker will receive notification of start date.

<table>
<tr><td rowspan="2">First Name:

Last Name:

Telephone:

Cell:

E-mail:

Alternate Contact:

Can we leave a message?
☐ YES ☐ NO</td><td>Referral Source?</td><td>Date of Birth:</td><td rowspan="2">What type of residence do you live in?
(e.g. own home, apartment, shelter, hospital)</td><td rowspan="2">Who do you live with?
(e.g. self, spouse, children, Non-relatives)?</td></tr>
<tr><td>Telephone:</td><td>Address:</td></tr>
<tr><td></td><td>Gender
☐Male ☐Trans
☐Female ☐Other
☐Choose not to disclose</td><td>What is your preferred language?</td><td>Are you of aboriginal descent?

☐ YES ☐ NO</td><td>What is your mental health Diagnosis (If known)?</td></tr>
<tr><td></td><td>What is your source of Income?</td><td colspan="2">What is the highest level of education you have completed?
Elementary ☐ Some College/University ☐
Some High school ☐ College/University ☐
High school ☐</td><td>Are you currently?

In School ☐
Working ☐</td></tr>
<tr><td colspan="5">REASON FOR REFERRAL</td></tr>
<tr><td colspan="5">OFFICE USE ONLY:</td></tr>
<tr><td colspan="3">INITIAL CONTACT DATE:</td><td colspan="2">MESSAGE LEFT: ☐Y WORKER:</td></tr>
<tr><td>Appointment Booked: ☐
Date: Time:</td><td colspan="2">Completed by:</td><td colspan="2">Entered into CRMS
☐Y ☐N</td></tr>
</table>

DATE: _____ **YOUTH TRANSITIONS INDEPENDENT LIVING GROUP**

PLEASE FAX TO: 705-748-2577 ATT: MELANIE KING