

**CMHA Intake & Brief Services 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.**  
Peterborough: 466 George Street North, Peterborough, ON, K9H 3R7 Phone: 705-748-6711 Fax: 705-748-2577  
Kawartha Lakes: 33 Lindsay Street South, Lindsay, ON, K9V 2L9 Phone: 705-328-2704 Fax: 705-328-245  
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 1-866-995-9933**

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| **PERSONAL INFORMATION:** | | |  |  |
| Name: | | | Date: | |
| Date of Birth: | | | **Health Card #:** | |
| Address: | | | Gender: | Pronoun(s): |
| Language Spoken: | | Do you Identify as Indigenous: Yes No Unknown | | Culture: |
| Preferred Method of Contact:  Phone  E-mail  Text Message  Email:       Telephone:       Alternate #:  Can we leave a message: Yes No | | | | |
| **HOUSING:** | | | | |
| Where do you live?  Market Rent Apartment  Market Rent House  Rooming / Boarding House  Homeless/ Couch Surfing  Hospital / Facility  Non-Profit / Subsidized Housing  With Parents / Primary Caregiver | | | | |
| Who do you live with? | | | | |
| **INCOME:** | | | | |
| What is your Primary Source of Income?  Employed  Ontario Works  ODSP  CPP Employment Insurance  Accident/Sickness/Disability Insurance  Other: | | | | |
| **LEGAL:** | | | | |
| Current Legal Status:  No Legal Problems  Incarcerated  On Probation  Awaiting Trial (criminal charges)  On Parole  Criminal Record  Unknown | | | | |
| EDUCATION: | | | | |
| Are you currently in school? Yes No  What is the highest level of education you have completed?  Elementary  High School  College  Completed University  Apprenticeship  Other: | | | | |
| **BARRIERS:** |  | | | |
| Do you identify with any barriers to your Daily Activities?  Physical / Mobility  Mental Health  Deaf / Hearing Impairment  Chronic Illness  Intellectual Disability  Blind / Visually Impaired  Learning Disability  Substance Use  Agility  Head Injury/ Cognitive  Childcare Needs  Transportation  Other please specify: | | | | |
| WHAT OTHER SERVICES ARE YOU CURRENTLY INVOLVED WITH? (e.g: 4CAST, VCCS, AOP, ACTT) | | | | |
|  | | | | |
| DIAGNOSIS / HEALTH INFORMATION: | | | | |
| Do you have a family doctor?  Yes  No Name:Do you have a psychiatrist?  Yes  No Name:       I | | | | |
| Do you have a mental health diagnosis? Anxiety  Depression  Bipolar Disorder  Schizophrenia  Borderline Personality Disorder  PTSD  Other – please specify: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| SUPPORT NEEDS: | | | | |
| Please describe the needs/concerns that you are seeking support for: | | | | |
| **REFERAL SOURCE:** | | | | |
| Self  Other Name:  Agency (If Applicable):  Relationship to Client:  Telephone:       Email:  Consent Attached?  Yes | | | | |
| Does the client consent to this referral?  Yes  No **Please note that we may need to contact the referral source for further information.** | | | | |