

**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.**   |