

**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  Some High School  High School  Some College  College  Some University  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.** | | | | |