Referral Form
Safe Beds

E-mail the completed referral from to: safebeds @cmhahkpr.ca
Call: 705 745 6484

Client Information:

Client Name	
Address	
City, Postal Code	
Telephone	
Date of Birth	

Reason for Referral:
What do you hope to gain from a referral to short term, intensive mental health/crisis support in a residential setting?

Current Supports:
What supports does the client have in place? (Formal and informal)
What do these supports do for the client?

Client consent gained. Yes	Verbal consent. Yes
Name of referrer and contact information:	Date: