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

Mental Health 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 appointment. If you are thinking of suicide, experiencing emotional distress, or you are worried about someone you know, you can call 9-8-8.

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 ☐ Homeowner

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:

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.**