

**CMHA Trustee Program Referral Form**

**Instructions: Please complete all fields to the best of your ability and submit the completed referral to the appropriate office.**
Peterborough: 466 George Street North, Peterborough, ON, K9H 3R7 Phone: 705-748-6711 Fax: 705-748-2577 ptbotrustee@cmhahkpr.ca
Kawartha Lakes: 33 Lindsay Street South, Lindsay, ON, K9V 2L9 Phone: 705-328-2704 Fax: 705-328-2456 kltrustee@cmhahkpr.ca

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| **PERSONAL INFORMATION:** |  |  |
| Name:       | Date:       |
| Date of Birth:       | **Health Card #:**       |
| Address:       | Preferred Method of Contact: [ ]  Phone [ ]  E-mail [ ]  TextEmail:       Telephone:       Alternate #:      Can we leave a message: [ ] Yes [ ] No  |
| **Does the client consent to this referral?** [ ]  Yes [ ]  No Does the client consent for us to contact the referral source? [ ]  Yes [ ]  No**Please note that we may need to contact the referral source for further information.**   |
| **INCOME:** |
| What is your Primary Source of Income?[ ]  Employed [ ]  Ontario Works [ ]  ODSP [ ]  CPP [ ]  Employment Insurance [ ]  Accident/Sickness/Disability Insurance [ ] Other:       |
| WHAT OTHER SERVICES ARE YOU CURRENTLY INVOLVED WITH? (e.g.: 4CAST, VCCS, AOP, ACTT) |
|  |
|  Do you have a mental health diagnosis or difficulty managing symptoms of mental illness? [ ]  Anxiety [ ]  Depression [ ]  Bipolar Disorder [ ]  Schizophrenia [ ]  Borderline Personality Disorder [ ]  PTSD [ ]  Other – please specify: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| SUPPORT NEEDS |
| Please describe how the program would benefit the client:       |
| **REFERRAL SOURCE:**  |
| [ ]  Self [ ]  Other Name:       Agency (If Applicable):      Relationship to Client:       Telephone:       Email:       Consent Attached? [ ]  Yes [ ]  No |