

**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](mailto:ptbotrustee@cmhahkpr.ca)  
Kawartha Lakes: 33 Lindsay Street South, Lindsay, ON, K9V 2L9 Phone: 705-328-2704 Fax: 705-328-2456 [kltrustee@cmhahkpr.ca](mailto:kltrustee@cmhahkpr.ca)

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| **PERSONAL INFORMATION:** |  |  |
| Name: | Date: | |
| Date of Birth: | **Health Card #:** | |
| Address: | Preferred Method of Contact:  Phone  E-mail  Text  Email:  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) | | |
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| 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 | | |