Name: ____

DOB: ______________________ Gender: _______________

MCP#: ____

Address: ____

P.O. Box: ____

Phone # : (H) _________________ (W) _________________

Leave Message: [ ] Home [ ] Work

Emergency Contact: ________________ Phone # __________

Parent / Guardian (if client is under 16): ___________________

Mental Health and Addictions Services Referral Form

Referral Date: __________________________________

Referred by: ___________________________________

Agency: _______________________________________

Phone #: ______________________________________

Is individual requesting referral? Yes [ ] No [ ]

Is individual aware of referral? Yes [ ] No [ ]

Are parents aware of this referral? Yes [ ] No [ ]

Family Physician: ______________________________

Phone: _______________________________________

Psychiatrist: ___________________________________

Phone: _______________________________________

Diagnosis / Presenting Issue: ____

Reason for Referral: ____

____

____

____

Is this individual having thoughts of Suicide and/or had a Suicide Attempt? ______________________

____

Other Treatments: Yes [ ] No [ ]

If yes, please specify: ______________________________

____

Current Medication Profile Attached: Yes [ ] No [ ]

Other Documents Attached: Yes [ ] No [ ]

Specify: ____

Mental Health and Addictions Services Use Only

Intake Worker: ________________________________ Date: ________________________________

Contacts:	Date	Time	Comments

LGH # 214
March 2011; May 2016; April 2017