

MENTAL HEALTH & SUBSTANCE USE SERVICES REFERRAL FORM

DATE:

Refer to: Mental Health		Urgent		Within	a Week		Witl	hin a Month	
ddress		Last		First	Initial	DOB		Gen	der
Postal Emergency Contact:	IAME							Male / I	emale
Refer to: Mental Health	Address					Minor Child	Yes	No	
Refer to: Mental Health Other: Harvey SU/A Family Counseling Vince SU/A Counseling Services Pickering, RP NLX MH 1.) Permission to call and/or leave a message? YES NO 2.) Is the client aware of this referral? YES NO 3.) Has this person been hospitalized within the past 30 days? YES NO Date: 4.) Reason for referral (Please include functional/behavioural changes): 5.) Previous Diagnosis (mental health, addictions, medical): 7.) Is there a suicide risk? YES NO 3.) Are there any safety concerns for the client or towards workers? YES NO (e.g. Victim of abuse/violence in a relationship, history of aggression, etc.) If yes, please specify:	City			Postal		Emergency Contac	et:		
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(Drint Assessment Contact Information)	∍.) K€	ererrai Agency/Perso	ווע						
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PLEASE ATTACH ANY ADDITIONAL PERTINENT INFORMATION