Huron Community Mental Health Service Referral Form
To be used by Community Agencies

We welcome your referral. Please be aware that we are not a Crisis agency and there is a wait time for service. All sections of this form must be complete in order to proceed with the referral.

Date:	**Health Card#**	**Version**:

Name:	**Gender**: ☐ M ☐ F ☐ Other	**Marital Status**:
Address: **Postal Code**:	**911 Address**:	
Mail Correspondence accepted: ☐ Yes ☐ No	**Birth date**:	**Age**:
Telephone Numbers (Primary): **Messages can be left?** ☐ Yes ☐ No	(Secondary): Messages can be left? ☐ Yes ☐ No	
Emergency Contact:	Relationship:	
Address:	Telephone Number:	
Family Physician: **Psychiatrist**: If no psychiatrist, has a referral been made? ☐ Yes ☐ No	**Phone #**: **Phone #:**	

Allergies: ☐ **Yes No** ☐ **If yes, specify:**	
Are there any barriers to accessing service? (Language, communication, physical, visual etc.)	☐ Yes ☐ No : **If yes, specify:**
Referral Source:	**Agency**:
Phone:	**Is individual aware of this referral**? ☐ Yes ☐ No
Previous client of our program? ☐ Yes ☐ No	**How long ago**?
Is this referral prompted by a situational crisis?	☐ Yes ☐ No
Please provide the date of the situational crisis and details of the crisis	**Date of Crisis:**
Details:	
Is there a formal diagnosis of mental illness? ☐ Yes ☐ No Unsure ☐ If yes, please describe**:**	
Are there major medical issues that impact mental health? (Please state)	
Medication List:	

Previous Psychiatric Hospitalizations? ☐ Yes ☐ No

Dates	Details

Past suicide attempts? ☐ Yes ☐ No **Self-Harming?** ☐ Yes ☐ No **Substance abuse?** ☐ Yes ☐ No

Please list substances:

Describe / List Symptoms	Rating of Symptoms (mild, moderate, severe)	Duration of Symptoms

Please describe the nature of functional impairment in the following areas as a result of the mental health symptoms.

Vocational/Occupational Function:

Interpersonal functioning and relationships:

Daily chores and routines:

Ability to manage stress and crisis situations:

Please briefly describe the reasons(s) for referral, including what lifestyle, behavioural, cognitive, or emotional changes they would like to make in regards to their mental health:

Huron Community Mental Health Services is a skills-based agency that focuses on goal-directed skills training.

Is client agreeable to attending groups? ☐ Yes ☐ No
Is client agreeable to completing between session practices, exercises and homework? ☐ Yes ☐ No
Is client agreeable with goals and attending this agency? ☐ Yes ☐ No

Has this client made use of other services? ☐ Yes ☐ No. If yes, which services?

Are there other services currently involved? ☐ Yes ☐ No. If yes, please list:

Following referral, will your agency continue to support the client? ☐ Yes ☐ No

Please describe your current treatment plan with the client, including what treatment goals have already been met:

Are there any safety risks staff should be aware of in delivering service? ☐ Yes ☐ No **If yes**, specify:

Are you aware of this individual ever having engaged in episodes of harm to people, or damage to property (fire setting, vandalism, etc.)
If yes, specify**:**

Criminal Charges	No	Yes	Unknown	Charge	When	Disposition & Comments
Current Charges	☐	☐	☐			
Past Charges	☐	☐	☐			

Form Completed by:_____ **Fax #:** _____

Fax the COMPLETED Form to 519-524-9349.

Upon review of referral and if appropriate for our service, an appointment date will be faxed to you. This appointment **must be confirmed** by contacting our administrative assistant either by fax 519-524-9349 or by phone 519-524-8316 ext 5750