



Huron Community Mental Health Services Referral Form To be used by Family Health Teams and Family Doctors

(formerly Community Psychiatric Service)

**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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Marital Status:
Address:	911 Address:	
Postal Code:		
Mail Correspondence accepted: <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth date:	Age:
Telephone Numbers (Primary):	(Secondary):	
Messages can be left? <input type="checkbox"/> Yes <input type="checkbox"/> No	Messages can be left? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact:	Relationship:	
Address:	Telephone Number:	
Family Physician:	Phone #:	
Psychiatrist:	Phone #:	
If no psychiatrist, has a referral been made: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, specify:		
Are there any barriers to accessing service? (Language, communication, physical, visual etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No : If yes, specify:	
Referral Source:	Agency:	
Phone:	Is individual aware of this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous client of our program? <input type="checkbox"/> Yes <input type="checkbox"/> No	How long ago?	
Is this referral prompted by a situational crisis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please provide the date of the situational crisis and details of the crisis	Date of Crisis:	
Details:		
Primary Psychiatric Diagnosis:		
Secondary Psychiatric Diagnosis:		
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

Describe and state the degree of functional impairment in the following areas (please rate as mild, moderate or severe):

Social: Mild Moderate Severe

Please Describe:

Occupation: Mild Moderate Severe

Please Describe:

Adaptive: Mild Moderate Severe

Please Describe:

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:

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

What problem area(s) / goals do you wish this individual to address through attending HCMHS?

Is client agreeable with goals and attending this agency? Yes No

Are there any safety risks staff should be aware of in delivering service? Yes No Unknown

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Past Charges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

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