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**: ☐ 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:		
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	☐	☐	☐			
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