Huron Community Mental Health Services
Referral Form

Please note, our service is unable to provide support in an emergency. If your client is experiencing a mental health crisis and requires immediate help, advise them to contact the Huron Perth Helpline and Crisis Response Team at 1-888-829-7484 or go to the nearest emergency department.

All sections of this form must be complete in order to proceed with the referral.

This referral form is for individual/group counselling services. To refer to a psychiatrist, please contact the department of psychiatry with Alexandra Marine & General Hospital at 519-524-8323 ext. 5361 or 5388

Date:	**Health Card#**	**Version**:
Legal Name (on health card): **Preferred name:**	**Gender**: ☐ M ☐ F ☐ Other Preferred pronouns: _____/_____	**Marital Status**:
Mailing Address: **Postal Code**:	**911 Address**: **Email address**: @	
Correspondence accepted: Mail ☐ Yes ☐ No Email ☐ Yes ☐ No	**Birth date**: DD/MM/YYYY	**Age**:
Telephone Numbers (Primary): **Messages can be left?** ☐ Yes ☐ No	(Secondary): Messages can be left? ☐ Yes ☐ No	
Emergency Contact:	Relationship:	
Address:	Telephone Number:	
Primary Care Provider: **Psychiatrist:** **Other Service Providers:**	**Phone Number:** **Phone Number:** **Phone Number:**	
Previous client of our program? ☐ Yes ☐ No	**How long ago**?	
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:	**Fax #:**	

Current safety factors: Assess and check all that apply below and provide details.

☐ Passive suicidal thoughts ☐ Active suicidal thoughts ☐ History of suicide attempt

☐ Substance use ☐ Thoughts to harm others ☐ History of violence/aggression

☐ Current intentional self-harm behaviours ☐ Behaviour influenced by hallucinations/delusions

Other:

Details:

Mental Heath Diagnosis (if known):

Previous Mental Health Hospitalizations ☐ **Yes** ☐ **No** If yes, please provide details:

Previous Mental Health Treatment ☐ **Yes** ☐ **No** If yes, please provide details**:**

Presenting Symptoms. Check all that apply and provide details below:

☐ Mood	☐ Anhedonia	☐ Obsessions/compulsions	☐ Hypersomnia/insomnia
☐ Apathy	☐ Hallucinations	☐ Interpersonal conflicts	☐ Disordered eating/eating disorder
☐ Delusions	☐ Thought control	☐ Unusual speech/behaviour	☐ Post-traumatic stress
☐ Panic attacks	☐ Anxiety	☐ Emotional dysregulation	
☐ Fear/paranoia	☐ Phobias – specify _____		

Other: _____

Details:

Reason for Referral and Goals for Treatment

May include lifestyle, behavioural, cognitive, or emotional changes they would like to make with regards to their mental health.

Has this referral been discussed with the client?	☐ Yes	☐ No
Have you discussed with your client that services may include participation in groups?	☐ Yes	☐ No
Is the client willing to accept services?	☐ Yes	☐ No

Relevant Medical History:

Other Psychosocial Issues:

☐ Marital/custody	☐ Abuse	☐ Financial	☐ Housing	☐ Work
☐ Situational Crisis	☐ On Trial	☐ Charges Pending	☐ Other	

Are there any safety risks, past charges, episodes of harm towards others, or property damage that staff should be aware of in delivering services? ☐ Yes ☐ No

If yes, specify:

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