Reset Form

COMMUNITY MENTAL HEALTH SERVICES

ADULT REFERRAL FORM

Call Toll Free: 1-888-310-4593

REFERRAL DATE (DD/MMM/YYYY): _____ ☐ YES ☐ NO

CLIENT NAME: _____ _____ GENDER: _____
(FIRST NAME) (LAST NAME)

D.O.B: _____ AGE: _____ PHIN #: _____ MHSC #: _____
(DD/MMM/YYYY)

ADDRESS: _____ _____ _____ _____
(STREET#/ NAME/ BOX #) (TOWN/CITY) (PROVINCE) (POSTAL CODE)

HOME PHONE #: _____ CELL #: _____ **PERMISSION TO LEAVE VOICEMAIL**? ☐ YES ☐ NO

BEST METHOD OF CONTACT: _____

ABORIGINAL STATUS: ☐ YES ☐ NO

IS THE CLIENT AWARE AND AGREEABLE TO MENTAL HEALTH SERVICES? ☐ YES ☐ NO

NAME OF REFERRAL SOURCE: _____

☐ SELF ☐ PARENT/GUARDIAN ☐ PHYSICIAN ☐ SCHOOL _____ ☐ OTHER _____

REFERRAL SOURCE TELEPHONE #:_____ FAX #:_____

ADDRESS: _____ _____ _____ _____
(STREET#/ NAME/BOX #) (TOWN/CITY) (PROVINCE) (POSTAL CODE)

INTERPRETATION SERVICES (available, if required): ☐ Language: _____

REASON FOR REFERRAL: **(CHECK ALL THAT APPLY):**

☐ DEPRESSION	☐ CHANGES IN MOOD/BEHAVIOR	☐ SLEEP / APPETITE DISTURBANCE
☐ ANXIETY	☐ MANAGING ILLNESS	☐ SUBSTANCE USE
☐ HEARING VOICES or SEEING THINGS	☐ UNUSUAL THOUGHTS/IDEAS	☐ TRAUMA
☐ MEMORY CONCERNS	☐ RECENT LOSS / LIFE CHANGE	☐ THREATS / HARM TO OTHERS
☐ THOUGHTS TO END LIFE ☐ Recent ☐ Past	☐ SELF-HARM ☐ Recent ☐ Past	☐ OTHER_____

(PLEASE SPECIFY)_____

_____

_____

_____

_____

_____

_____

_____

If this is a mental health emergency please call the mental health crisis line at 1-888-617-7715 or 1-866-588-1697 or proceed to your local hospital emergency department.

DIFFICULTIES WITH: (Check all that APPLY):

☐ FINANCES	☐ EMPLOYMENT/SCHOOL	☐ FAMILY/SOCIAL RELATIONSHIPS
☐ HOUSING	☐ MANAGING DAILY LIVING TASKS	☐ ALCOHOL/DRUGS/GAMBLING
☐ MEMORY/THINKING PROBLEMS	☐ MANAGING ILLNESS SYMPTOMS	☐ MANAGING MEDICATION

Please specify: _____

DURATION OF PROBLEM: ☐ *Under 3 months* ☐ *6-12 months* ☐ *1year+*

IS THIS A NEW CONCERN: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY…) _____

OTHER AGENCIES INVOLVED: (e.g. Public Trustee, Power of Attorney, Employment & Income Assistance, Child & Family Services, Workers Compensation Board, Manitoba Public Insurance, Probation, Housing supports, Court/Legal matters, Adult Community Disability Services)

☐ YES ☐ NO If yes, please specify: _____

MENTAL HEALTH HISTORY**:** _____
_____
_____

NAME OF PSYCHIATRIST/PSYCHOLOGIST/OTHER MENTAL HEALTH PROFESSIONAL: _____

ACCESS TO EMPLOYEE ASSISTANCE PROGRAM OR GROUP HEALTH: ☐ YES ☐ NO

If yes, please specify: _____

FAMILY PHYSICIAN: _____

PAST/PRESENT MEDICAL CONDITIONS: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY…) _____

PAST/PRESENT MENTAL HEALTH DIAGNOSIS: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY…) _____

PAST/PRESENT MEDICATIONS: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY…) _____

PLEASE INCLUDE ALL RELEVANT ASSESSMENTS, HOSPITAL DISCHARGE SUMMARIES, PSYCHIARTY AND/OR PSYCHOLOGY REPORTS, OCCUPATIONAL THERAPY OR OTHER RELEVANT REPORTS.

SIGNATURE OF PERSON COMPLETING THE REFERRAL: _____

******* Missing Information will delay the referral process *******

PLEASE SEND COMPLETED FORM BY FAX TO MENTAL HEALTH ACCESS SERVICES AT 204-326-1680

Bonjour Hello CE DOCUMENT EST AUSSI DISPONIBLE EN FRANCAIS

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