CAMHS
Community Addiction and Mental Health Services of Haldimand & Norfolk

❑**Adult Mental Health** Fax Simcoe office**: 519-426-3257**
❑**Specialized Geriatric Services** **OCAN COMPLETED ❑ YES ❑ NO** Fax Townsend office**: 519-587-4118**
❑**BSO LT C** ❑**IGSW**
❑**PRC**

**** FAILURE TO PROVIDE ADEQUATE INFORMATION DOES DELAY THE REFERRAL PROCESS ****

CLIENT IDENTIFICATION

Name _____ Male/Female Date of Birth (DD/MM/YR) _____

Address _____City _____ Postal Code _____

Current Living Arrangements: ❑ Living Alone ❑ family ❑ spouse ❑ other _____

Telephone _____ (alternate phone) _____ ❑ No Phone Available

Health Card # _____Version Code _____ Family Doctor _____

FAMILY CONTACT INFORMATION (please fill out for Specialized Geriatric Referrals)

Name _____ Relationship _____

Address _____Phone _____ Alternate Phone _____

SYMPTOMS: (please check all that apply)

❑ current suicidal ideation/plan
❑ worries excessively/panic attacks
❑ racing thoughts
❑ paranoid thoughts/delusions
❑ past suicide attempts
❑ feelings of hopelessness/worthlessness
❑ change in energy level
❑ memory impairment
❑ acute confusion
❑ excessive irritability/agitation
❑ intrusive repetitive thoughts
❑ hallucinations
❑ loss of interest
❑ sadness/depressed mood
❑ changes in sleeping pattern
❑ change in speech/behavior
❑ wandering/exit seeking
❑ falls/instability/dizziness

PSYCHOSOCIAL ISSUES:

❑ financial issues
❑ marriage/relationship
❑ anger/temper
❑ bereavement
❑ legal issues
❑ CAS (Children's Aid)
❑ housing issues
❑ school/work problems
❑ caregiver burden/stress

Is accessing EAP (Employment Assistance Program) an option: ❑ Yes ❑ No ❑ Unknown
Is the client known to CCAC (Community Care Access Centre): ❑ Yes ❑ No ❑ Unknown

Previous Psychiatric Treatment/Diagnosis: _____
_____

Current Medications: _____
_____

Significant Medical Problems (details): _____
_____ Drug Allergies_____

Addiction Issues:
Current substance use (specify) _____ Gambling activities _____
Previously attended Addiction Services_____ _____

Reason for referral:
❑ consult regarding diagnosis and treatment
❑ medication assessment
❑ counseling only

} Doctor's signature required

_____ _____
Referring Doctor's Signature **Date**