CAMHS
Community Addiction and Mental Health Services of Haldimand and Norfolk

FAX REFERRAL: 519-426-3257

CLIENT IDENTIFICATION

Name_____ Identifies as □ M □ F Date of Birth (DD/MM/YY)_____

Address _____ City _____ Postal Code _____

Phone _____ Alternate Phone _____ □ No Phone Available

Permission to leave message □ Yes □ No Permission to text □ Yes □ No

Health Card # _____ Version Code _____ Expiry Date (DD/MM/YY) _____

Family Doctor _____ Current Living Arrangements □ Spouse □ Family □ Living Alone □ Other

FAMILY CONTACT INFORMATION (please fill out for Geriatric Referrals)

Name _____ Relationship _____ Phone _____

Address _____ Alternate Phone _____

Reason for Referral:(e.g. not improving with meds, worsening symptoms, family/patient request)

CURRENT Symptoms/Concerns include:

**** IF A CONCERN FOR SAFETY IS AN ISSUE (E.G. ACTIVE SUICIDE INTENT/PLAN), PLEASE REFER TO THE EMERGENCY DEPARTMENT FOR ASSESSMENT.**

Service referred to: □ Adult Mental Health □ Telemedicine □ Addictions (Self-Referral)
□ Specialized Geriatric □ Intensive Geriatric Service Worker □ BSO COT

Is there a concern that this person has a Concurrent Disorder? □ Yes □ No

CURRENT Presenting Symptoms/Concerns: (Please check all that apply)

□ **current** suicidal thoughts
□ acute confusion
□ anger/temper
□ anxiety
□ bereavement
□ caregiver burden/stress
□ CAS involvement
□ change in energy level
□ change in sleep pattern
□ change in speech/behaviour
□ disorganized thoughts
□ excessive irritability/agitation
□ falls/instability/dizziness
□ feelings of hopelessness/worthlessness
□ financial issues
□ hallucinations
□ housing issues
□ intrusive repetitive thoughts
□ legal issues
□ loss of interest
□ interpersonal relationships
□ memory impairment
□ paranoid thoughts/delusions
□ past suicide attempt(s)
□ physical health concerns
□ racing thoughts
□ sadness/depressed mood
□ school/work problems
□ wandering/exit seeking
□ worries excessively/panics

□ **Addiction Issues**: Current substance use (specify) _____
□ Gambling □ Previously Attended Addiction Services

Symptoms/Concerns filled out by: □ Health Care Practitioner □ Client

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

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Clients Name:

Previous Psychiatric Treatment/Diagnosis:

Current Medications:

Significant Medical Problems (details):

Service Request:

- □ **Diagnosis & Treatment Plan by Physician/Specialist – Doctor/Nurse Practitioner Signature Required**
- □ **Medication Assessment by Physician/Specialist – Doctor/Nurse Practitioner Signature Required**
- □ Counselling Only

Health Care Practitioner: (Please print name)	**Billing #**	**Signature (required)**	**Date**

Self-Referral: (Please print name)	**Signature (required)**	**Date**

FAILURE TO PROVIDE ADEQUATE INFORMATION DOES DELAY THE REFERRAL PROCESS

Please Note: Because of the volume and complexity of patients referred to our clinic, we cannot assume any medical or legal responsibility for their healthcare while they are waiting consultation.