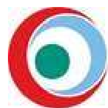

CAMHS
Community Addiction and Mental Health Services of Haldimand and Norfolk

FAX REFERRAL: 519-587-4118

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 □ disorganized thoughts □ interpersonal relationships □ acute confusion □ excessive irritability/agitation □ memory impairment

□ anger/temper	□ falls/instability/dizziness	□ paranoid thoughts/delusions
□ anxiety	□ feelings of hopelessness/worthlessness	□ past suicide attempt(s)
□ bereavement	□ financial issues	□ physical health concerns
□ caregiver burden/stress	□ hallucinations	□ racing thoughts
□ CAS involvement	□ housing issues	□ sadness/depressed mood
□ change in energy level	□ intrusive repetitive thoughts	□ school/work problems
□ change in sleep pattern	□ legal issues	□ wandering/exit seeking
□ change in speech/behaviour	□ loss of interest	□ 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.