APPENDIX E

Health Sciences North/Horizon Santé Nord

*For office use only** SH: _____ Date Received: _____
Date of screening: _____ Start time: _____ End Time: _____

Date of Referral *(DD/MM/YYYY):*_____

Mental Health and Addiction Program Referral Form

Client/Patient Information

Legal Name *(Last name, First name):*
_____
Preferred Name *(If Applicable):*
_____
Date Of Birth *(DD/MM/YYYY):* _____**Age**: _____
Health Card Number: _____**VC:** _____
Expiry date *(DD/MM/YYYY):* _____
Address: _____
Postal Code:_____
Telephone number(s) *(Specify home, cell, etc.)*
Home: _____
Cell: _____
Please confirm if confidential messages can be left?
❒ Yes ❒ No
Email address *(If any):* _____
Can we send correspondence to this email address?
❒ Yes ❒ No
What is your mother tongue?
❒ English ❒ French ❒ Other_____
If your mother tongue is neither French nor English, in which of Canada's official languages are you most comfortable?
❒ English ❒ French
Is there a need for an interpreter?
❒ Yes ❒ No *(If yes, specify details)*:_____
Do you have accessibility needs? ❒ Yes ❒ No
If yes, specify_____
Is there an alternative contact? ❒ Yes ❒ No
Name:_____
Relationship to client/patient: _____
Telephone number:_____
What is your gender identity? _____
Your Pronouns:_____
What is Your Ethnicity: _____
Please include short explanation as to reason for referral.
_____
_____

Referral information

Referral source type:
❒ Family Physician ❒ Community Program
❒ Nurse Practitioner ❒ Self-referral
❒ Psychiatry ❒ Other (specify):_____
❒ Regulated Health Professional (specify):_____
Name of Referral Source *(Last name, First name):*
_____
Billing Number: _____
Address:_____
Telephone Number: _____
Fax Number:_____
Have you been seen by a psychiatrist previously?
❒ Yes ❒ No **If yes, name of psychiatrist** *(Last name, First name)*:_____
Do you still see psychiatrist?
❒ Yes ❒ No
Have you been involved in Mental Health and Addiction Programming in the past?
❒ Yes ❒ No **If yes, what program?**
_____
Are you still involved in program?
❒ Yes ❒ No
Present State:_____
Are you here to refer yourself to a program?
❒ Yes ❒ No
At this time are you experiencing any:

Suicidal thoughts?	❒ Yes	❒ No
Thoughts of hurting anyone else?	❒ Yes	❒ No
Are you able to keep yourself safe?	❒ Yes	❒ No
Do you have any weapons on you?	❒ Yes	❒ No

Reviewed by: _____

Mental Health Programs (Check which service you are requesting):
❒ Mood and Anxiety Program (MAP)
❒ Eating Disorder Program
❒ Early Psychosis Intervention Program
❒ Case Management ***(May require psychiatric referral)***
❒ Perinatal Mental Health Program
❒ Ontario Structured Psychotherapy-PHQ-9:___GAD-7:___
Addiction Services (Check which service you are requesting):
❒ Outpatient Addictions
❒ Outpatient Gambling Services
❒ Rapid Access Addiction Medicine (RAAM)
❒ Withdrawal Management Services

MENTAL HEALTH AND ADDICTION PROGRAM REFERRAL FORM - FAX TO: 705-669-1594