Haldimand and Norfolk Mental Health Service Providers

REFERRAL FORM

This form is to be used for accessing mental health services for adults in Haldimand and Norfolk

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

Address _____ Postal Code _____ ❑ Living Alone

Telephone _____ (alternate phone) _____ ❑ No Phone Available

Health Card # _____ Version Code _____ Family Doctor _____

Symptoms/Other Issues: (Please check all that apply.)

- ❑ angry, irritable, agitated
- ❑ anxiety, panic
- ❑ appetite: increase/decrease
- ❑ behavior problems
- ❑ current suicide plan
- ❑ current suicidal thoughts
- ❑ developmental delay
- ❑ disorientation
- ❑ disturbances in thought
- ❑ energy: increase/decrease
- ❑ family pressure
- ❑ feelings of hopelessness
- ❑ feelings of worthlessness
- ❑ financial problems
- ❑ guilt
- ❑ hallucinations
- ❑ hearing/visual impairment
- ❑ housing issue
- ❑ marriage problems
- ❑ memory changes: recent/progressive
- ❑ mood changes
- ❑ obsessions, compulsions
- ❑ past suicide attempts
- ❑ physical disability
- ❑ physical movement: increase/slowed
- ❑ poor judgment/insight
- ❑ sadness
- ❑ significant medical problems
- ❑ sleep: increase/decrease
- ❑ substance use: drugs/alcohol
- ❑ uncooperative
- ❑ weight: gain/loss
- ❑ Are you a risk to others/self?

How have the symptoms, if at all, impacted your daily living? (e.g. work, social, self-care, etc.)

_____

_____

Additional information: (diagnosis (if known), duration, precipitating events, symptom details, other symptoms)

_____

_____

Current Medications: _____

_____

_____

Which services are currently used?:

- ❑ ABEL Enterprises
- ❑ Adult Mental Health Services
- ❑ Assertive Community Treatment Team
- ❑ Alzheimer's Society
- ❑ Canadian Mental Health Association/H-N
- ❑ Children's Aid Society
- ❑ Community Access Support Services
- ❑ Community Integration Worker
- ❑ Community Support Program - ENSH
- ❑ Employee Assistance Program
- ❑ Erie's North Shore Housing
- ❑ Family Doctor: date last visit: _____
- ❑ Friendly visitor
- ❑ HADC - Haldimand Association of Developmentally Challenged
- ❑ Haldimand-Norfolk Resource Centre
- ❑ Home Care (CCAC)
- ❑ Norfolk Association of Community Living
- ❑ Private psychiatrist/psychologist/Counselor Name: _____
- ❑ Psychiatric Hospital _____
- ❑ REACH
- ❑ Regional MH London Community Liaison Nurse
- ❑ Seniors: Support Services
- ❑ True Experience
- ❑ Other _____

For which of the following service(s) is the referral made?

- ❑ ABEL Enterprises - *work skills training, supported employment; business development*
- ❑ Adult Mental Health Services - *assessment; consultation; treatment; support; advocacy; counselling*
  - ❑ Referral seeking to switch from private psychiatrist to AMHS services
- ❑ Assertive Community Treatment Team - *intensive case management; community-based clinical service*
- ❑ Canadian Mental Health Association - *education; support group/workshop information; volunteer program*
- ❑ Community Support Program - *case management; support in Haldimand & Norfolk Counties*
- ❑ Erie's North Shore Housing - *housing for people with psychiatric problems in the Simcoe area*
- ❑ Specialized Geriatric Services - *specialized geriatric Assessment; Consultation; Treatment; Education*
- ❑ Regional MH London Community Liaison Nurse (formerly London Psychiatric Hospital)
- ❑ Haldimand-Norfolk Resource Centre - *peer support; recreational activities; education; advocacy*
- ❑ True Experience - *housing and work skills training in the Dunnville area*

Service Preferences; if any:

- ❑ Best Time to Call: _____
- ❑ Language: _____ ❑ Wheelchair Accessibility
- ❑ Location: _____ ❑ Other: _____

CONSENT TO DISCLOSURE

I, _____ hereby consent to the disclosure or transmittal of information to:
(name)

(please check the appropriate program to which you are giving consent, cross out those that don't apply)

- ❑ ABEL Enterprises
- ❑ Adult Mental Health Services of H/N
- ❑ Assertive Community Treatment Team
- ❑ Canadian Mental Health Association/H-N
- ❑ Community Support Program
- ❑ Erie's North Shore Housing
- ❑ Specialized Geriatric Services
- ❑ Regional Mental Health London Community Liaison Nurse
- ❑ Resource Centre
- ❑ True Experience

I understand that non-identifying information may be collected from this referral for statistical purposes.

Signature: _____ **Date:** _____
(note: client or legal substitute decision maker signature is necessary to process this referral.)

Witness Signature: _____ **Date:** _____

Referring Source: (please print) _____

Referring Source Signature: _____ **Date:** _____

Please mail or fax to: **ADULT MENTAL HEALTH SERVICES OF H-N**

216 West Street, Suite 103
SIMCOE, Ontario N3Y 1S8
Fax: (519) 426-3257

OR

26 Main St. North, Box 760
HAGERSVILLE, Ontario N0A 1H0
Fax: (905) 768-5804

For Assistance with the Form Phone: 1-877-909-4357 (HELP)