Canadian Mental Health Association
Windsor-Essex County
Mental health for all

CMHA REFERRAL FORM

Is the individual aware that a referral is being made on their behalf? ☐ Yes ☐ No

Client Personal Information:

Date of Birth ______ | ______ | ______
Month Day Year

Name: ____________________

Address: ____________________

____

☐ OK to send mail?

Phone: ____________ Alternate (cell): ____________

☐ OK to leave message? ☐ OK to leave message?

Gender ☐ Male ☐ Female ☐ Other ____________

Preferred Language: ☐ English ☐ French ☐ Other ____________

Mother Tongue ____________________

Aboriginal Origin ☐ Aboriginal ☐ Non-Aboriginal ☐ Unknown

Aboriginal Identity: ☐ First Nations ☐ Inuit ☐ Métis ☐ Non-Status Indians ☐ Urban Aboriginal

Health Card Number: ____________ Version Code: ____________

Marital Status ☐ Single ☐ Married ☐ Common-Law
☐ Separated ☐ Divorced ☐ Widow/Widower

Emergency Contact Information

Name: ____________________

Relationship: ____________________

Address: ____________________

____

Phone ____________ Alternate (cell): ____________

☐ Permission to contact if having difficulty locating client

Referral Source:

Referred By: ____________________ Date: ____________

Relationship: ____________________

Address: ____________________

____

Phone ____________________

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Reason for Referral:

- ☐ Specific symptoms of mental illness: ______
- ☐ Suicidal ideation or attempts: ☐ Yes ☐ No ☐ Unknown
- ☐ Education and support in coping with their illness: ______
- ☐ Substance abuse: ______

- ☐ Hospital admissions and reason for admission ☐ Yes ☐ No

______

- ☐ Date of most recent psychiatric hospitalization: ______ Month | ______ Day | ______ Year

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- ☐ Current Criminal Charges: ______
- ☐ Incarcerated / Release from Custody: ☐ Yes ☐ No ☐ N/A
- ☐ Other (Please specify): ______

______

Primary Diagnosis ______
Secondary Diagnosis ______
Psychiatrist: ______
Family Physician: ______

Medications: ☐ Unknown

______
______
______
______
______

	Yes	No	Unknown
Can medication be taken independently?	☐	☐	☐
Is medication taken as prescribed?	☐	☐	☐
Knowledge & Understanding of Effects & Side Effects	☐	☐	☐

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Physical Health Problem

- ☐ Diabetes
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Other: ____________________

Housing Status:

- ☐ Stable
- ☐ Homeless
- ☐ Unknown
- ☐ Other: ____________________

Primary Income Source

- ☐ Employment
- ☐ Disability Assistance
- ☐ Pension
- ☐ Ontario Works
- ☐ Family
- ☐ No Source of Income
- ☐ EI
- ☐ ODSP
- ☐ Unknown
- ☐ LTD
- ☐ CPP Disability
- ☐ Other: ____________________

Trustee Involved: ☐ Yes ☐ No ☐ Unknown

____________________ Signature of Referral Source

____________________ Signature of Client

If this referral is being completed by a Physician or Community Agency please attach any additional information which may be helpful in completing our assessment for the appropriate services.

Please fax the completed referral form to

CMHA-WECB
1400 Windsor Avenue
Windsor, ON N8X 3L9

FAX - 519-971-0058