Canadian Mental Health Association
Windsor-Essex County
Empowering transitions to wellness.

Fax to: (519) 971-0058

External Coordinated Access Referral Form

Is the individual aware that a referral is being made on their behalf? ☐ Yes ☐ No
Is the individual aged 16 or over? ☐ Yes ☐ No

Client Personal Information:
Name: _____
Address: _____ City: _____ Province: ____ Postal Code: _____
Date of Birth: ____/____/_____ Permission to send mail? ☐ Yes ☐ No
Phone: _____ Msg? ☐ Yes ☐ No Alternate Ph: _____ Msg? ☐ Yes ☐ No
Gender: ☐ Male ☐ Female ☐ Other: _____
Preferred Language: ☐ English ☐ French ☐ Other: _____
Mother Tongue: _____
Aboriginal Origin: ☐ Aboriginal ☐ Non-Aboriginal ☐ Unknown
Aboriginal Identity: ☐ First Nations ☐ Inuit ☐ Metis ☐ Non Status ☐ Urban
Health Card #: _____ Version Code: ____ Expiry Date: ____/____/_____
Marital Status: ☐ Single ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Information:
Name: _____ Relationship: _____
Address: _____ City: _____ Province: ____ Postal Code: _____
Phone: _____ Msg? ☐ Yes ☐ No Alternate Ph: _____ Msg? ☐ Yes ☐ No

Primary Diagnosis: _____ **Secondary Diagnosis:** _____

Is client experiencing Psychosis? ☐ Yes ☐ No **1st Experience with Psychosis?** ☐ Yes ☐ No

Other Illness / Disability:
- ☐ Concurrent Disorders (substance dependence with mental illness)
- ☐ Dual Diagnosis (developmental impairment with mental illness)
- ☐ Neurological (head / brain injury, epilepsy, cognitive disorders, etc.)
- ☐ Active Medical Conditions
  - ☐ Autoimmune Conditions ☐ Cancer ☐ Cardiac Disease ☐ COPD ☐ Diabetes
  - ☐ HIV ☐ HEP ☐ HTN ☐ Stroke
  - ☐ Other Chronic Illness, Physical disability, or sensory deficit: _____

Primary Symptom: _____ **Secondary Symptom:** _____

Does the client have a primary care provider (Dr / NP)? ☐ Yes ☐ No

Does the client have a Psychiatrist? ☐ Yes ☐ No

Is this client transitioning from a youth mental health program? (check all that apply)
☐ Child and Adolescent Psychiatry (Maryvale) ☐ Teen Health Centre ☐ Other: _____

Date of most recent psychiatric hospitalization: ____/____/_____

Reason for Admission: _____

Is the client currently discharged in the past month from a hospital inpatient mental health program?
☐ Yes (provide hospital unit name) ☐ No ☐ Not Sure: _____

Mental Health Risk Factors:

To what degree is the client's daily function impaired by their symptoms?	☐	Mild	☐	Moderate	☐	Severe
Is excessive recreational drug, alcohol use, or gambling a concern?	☐	Yes	☐	No	☐	Unsure
Is this referral for addictions treatment?	☐	Yes	☐	No		
Is there current involvement with an addictions treatment program?	☐	Yes	☐	No		
Is there involvement with a methadone program?	☐	Yes	☐	No		
Has the client had suicidal thoughts in the past month?	☐	Yes	☐	No	☐	Unsure
Has a plan to suicide?	☐	Yes	☐	No		
Has attempted to suicide in the past month?	☐	Yes	☐	No		
Is client engaging in self-harm?	☐	Yes	☐	No		
Does the client have a history of aggressive or destructive behavior?	☐	Yes	☐	No	☐	Unsure
Does the client have a history of criminal legal charges?	☐	Yes	☐	No	☐	Unsure
If female, is the client pregnant or has recently (24mths) given birth?	☐	Yes	☐	No		
Is peri-partum depression a concern?	☐	Yes	☐	No	☐	Unsure
Is the client currently homeless or at risk of becoming homeless?	☐	Yes	☐	No		
Are family / relationship issues affecting the client's mental health?	☐	Yes	☐	No		
Are socio-economic issues affecting the clients' mental health?	☐	Yes	☐	No		

Reason for Referral:

☐	Specific symptoms of mental illness: _____					
☐	Suicidal Ideation or attempts:	☐	Yes	☐	No	☐ Unsure
☐	Education & Supporting coping with their illness: _____					
☐	Substance Abuse supports & linkages: _____					
☐	Experiencing mental illness, current criminal charges (not in custody):	☐	Yes	☐	No	☐ Unsure
☐	Experiencing mental illness and incarcerated:	☐	Yes	☐	No	
☐	Requesting Counselling and Treatment for Depression and/or Anxiety					
	Newly Diagnosed?	☐	Yes	☐	No	
	History of chronic depression and / or anxiety?	☐	Yes	☐	No	
☐	Requesting supportive grief counselling for bereaved adult individual					

Other reasons including any clinical questions, diagnoses, description of symptoms, requested services, support needs, etc.

_____

Are you referring this individual to any other services at this time? ☐ Yes ☐ No

If yes, please list:

_____

Referral Source:

Referred By: _____ Date: ____/____/_____

Relationship: _____

Address: _____ City: _____ Province: ____ Postal Code: _____

Phone: _____

Referral Signature: _____ **Client Signature:** _____