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:** _____