



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:** _____