**CANADIAN MENTAL HEALTH ASSOCIATION**

**REFERRAL/APPLICATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRAL DATE:** |  | | **PHN:** | |  | | |
| **CLIENT NAME:** |  | | **BIRTHDATE:** | |  | | |
| **ADDRESS:** |  | | **GENDER:** | | **Male**  **Female** | | |
| **POSTAL CODE:** |  | | **CLIENT PHONE #:** | |  | | |
| **INCOME SOURCE** |  | | **OTHER CLIENT PHONE #:** | |  | | |
| **PARENT/GUARDIAN:**  **( if applicable)** |  | | **PARENT/GUARDIAN PHONE #:** | | |  | |
| **CLIENT’S PHYSICIAN:** |  | | **CLIENT’S PHYSICIAN PHONE #:** | | |  | |
| **CLIENT’S PSYCHIATRIST** |  | | **CLIENT’S PSYCHIATRIST PHONE #:** | | |  | |
| **CLIENT STATUS** | Independent/Dependent  Guardianship  Trusteeship  Personal Directive (if applicable) | | | | | | |
| **REFERRAL SOURCE:** | | **CASE MANAGER:** | | | | |
| **REFERRAL SOURCE CONTACT NAME:** | | | | **REFERRAL SOURCE PHONE #:** | | |
| **REASON FOR REFERRAL:**  **Club 4U**  **Group Home**  **Group Home Respite**  **College Program**  **(complete Individual Service Plan as appropriate)** | | | | | | |

**PERSONAL HEALTH INFORMATION/RISK ASSESSMENT**

|  |  |  |
| --- | --- | --- |
| **Category** | **Description/Comments** | **Severity (check one)** |
| **General history profile of health/wellness/ illness** (i.e. description & presentation, congenital and/or physical abnormalities, problems affecting function such as asthma, heart problems, psychological problems, etc.) |  | Severe (3)  Moderate (2)  Minor (1)  No difficulty (0) |
| **Allergies** (i.e. drugs, foods, or other problematic sensitivities) |  | Severe (3)  Moderate (2)  Minor (1)  No difficulty (0) |
| **Description of psychiatric or other conditions requiring support** (i.e. personality, anxiety, depression, paranoia, schizophrenia, motivation level, sleep difficulty, etc.) |  | Severe (3)  Moderate (2)  Minor (1)  No difficulty (0) |
| **Mobility and Motivation** (i.e. ability/motivation to ambulate, obtain/use transportation or be assisted with respect to daily living) |  | Severe (3)  Moderate (2)  Minor (1)  No difficulty (0) |
| **Condition/Risks requiring Attention/Caution** (i.e. alcohol or drug abuse, anxiety, danger or violence issues, hoarding, legal or sexual behavior issues, smoking, suicidal ideation, wandering, etc. |  | Severe (3)  Moderate (2)  Minor (1)  No difficulty (0) |
| **Summary** (any additional information required related to client referral) |  | **Total Severity Rating:** |

**CURRENT MEDICATION LIST**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Side-Effects Experienced** |
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For Office Use Only

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| --- | --- | --- |
| Date Referral Received: | | STATUS OF REFERRAL: Accepted Yes  No |
| Case Manager: | Phone #: |  |