**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

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