CENTRE Alliance CENTRE

172 Ethel St, Box D1
Sturgeon Falls, Ontario P2B 1V9
Tel: 705-753-2271/ Fax: 705-753-4202

REFERRAL FORM

*****Individual must be 16 years of age and reside within the Municipality of West Nipissing to qualify for services*****

Source of Referral (including phone number) _____

Name ___ _____ Date of Birth _____

Address _____

_____

Telephone Number _____ Language Preference ____ _____

Permission to leave message: ☐ *Yes* ☐ *No*
Permission to send correspondence: ☐ *Yes* ☐ *No*

Family Physician: _____ _____ _____ Psychiatrist: _____

Other Agencies/Services Involved with individual:

_____

_____

Diagnostic Categories - Please provide as much information as possible

- ☐ Adjustment Disorder
- ☐ Anxiety Disorder
- ☐ Delirium, Dementia, Amnesic and Cognitive Disorders
- ☐ Disorder of Childhood/Adolesc.
- ☐ Dissociative Disorders
- ☐ Eating Disorders
- ☐ Impulse Control Disorders not elsewhere classified
- ☐ Factitious Disorders
- ☐ Mental Disorders due to General Medical Condition
- ☐ Mood Disorders
- ☐ Personality Disorders
- ☐ Schizophrenia and other Psychotic Disorders
- ☐ Sexual and Gender Identity Disorders
- ☐ Sleep Disorders
- ☐ Somatoform Disorders
- ☐ Substance Related Disorders
- ☐ Developmental Handicap
- ☐ Unknown

Most Recent Psychiatric Diagnosis:_____

Previous Psychiatric Hospitalization(s): _____

Presenting Issues:

- ❑ Threat to others/attempted suicide
- ❑ Specific symptom of serious mental illness
- ❑ Physical/Sexual Abuse
- ❑ Educational
- ❑ Occupational/Employment/Vocational
- ❑ Housing
- ❑ Financial
- ❑ Legal
- ❑ Problems with relationships
- ❑ Problems with substance abuse/addictions
- ❑ Activities of Daily living
- ❑ Other

Medical Issues:

- ☐ Significant Medical/Physical Illness _____
- ☐ Chronic Pain _____
- ☐ Physical Symptoms Other Than Chronic Pain _____
- ☐ Medication Issues _____
- ☐ Other _____

Current Medication(s):

_____ _____
_____ _____
_____ _____

Intervention Requested:

- ☐ **Psychiatric Consultation**
- ☐ **Mental Health Counselling and Treatment**
- ☐ **Substance Abuse Services**
- ☐ **Intensive Case Management Services**

Additional Comments:

_____
_____
_____

Signature: _____ **Date:** _____