Referring Doctor: (please Print)

Date



FAX: Townsend 519-587-4118 • Simcoe 519-426-3257

CLIENT IDENTIFICATION Name	□ M □ F Date of Birth (DD/MM/YR)	
Address	City	Postal Code
Current Living Arrangements: Living Alone	☐ family ☐ spouse ☐ other	
Telephone	Alternate phone	No Phone Available
Health Card #	Version Code Family D	octor
FAMILY CONTACT INFORMATION (pleat	se fill out for Geriatric Referrals)
Name	Relationship	Phone
Address	Alternate Phone	
SYMPTOMS: (please o	check all that apply)	PSYCHOSOCIAL ISSUES:
□ current suicidal ideation/plan □ acute confusion □ change in energy level □ change in speech/behavior □ change in sleep pattern □ falls/instability/dizziness □ hallucinations □ feelings of hopelessness/worthlessness □ intrusive repetitive thoughts □ Addiction Issues: Current substance use (sp. Gambling Issues □ Profile Is accessing EAP (Employment Assistance Profile Is the client known to CCAC (Community Care	eviously Attended Addiction Services Program) an option: Yes	anger/temper bereavement caregiver burden/stress CAS involvement financial issues housing issues legal issues marriage/relationship school/work problems No Unknown No Unknown
revious Psychiatric Treatment/Diagnosis:		
Current Medications:		
Significant Medical Problems (details):		
Reason for Referral: Diagnosis and Treatme Medication Assessment Counseling only		

FAILURE TO PROVIDE ADEQUATE INFORMATION DOES DELAY THE REFERRAL PROCESS

Billing #

Signature (required)