

# Haldimand and Norfolk Mental Health Service Providers REFERRAL FORM

*This form is to be used for accessing mental health services for adults in Haldimand and Norfolk*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male/Female  
(DD/MM/YR)

Address \_\_\_\_\_ Postal Code \_\_\_\_\_  Living Alone

Telephone \_\_\_\_\_ (alternate phone) \_\_\_\_\_  No Phone Available

Health Card # \_\_\_\_\_ Version Code \_\_\_\_\_ Family Doctor \_\_\_\_\_

## Symptoms/Other Issues: (Please check all that apply.)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> angry, irritable, agitated  | <input type="checkbox"/> feelings of worthlessness             | <input type="checkbox"/> physical disability                   |
| <input type="checkbox"/> anxiety, panic              | <input type="checkbox"/> financial problems                    | <input type="checkbox"/> physical movement:<br>increase/slowed |
| <input type="checkbox"/> appetite: increase/decrease | <input type="checkbox"/> guilt                                 | <input type="checkbox"/> poor judgment/insight                 |
| <input type="checkbox"/> behavior problems           | <input type="checkbox"/> hallucinations                        | <input type="checkbox"/> sadness                               |
| <input type="checkbox"/> current suicide plan        | <input type="checkbox"/> hearing/visual impairment             | <input type="checkbox"/> significant medical problems          |
| <input type="checkbox"/> current suicidal thoughts   | <input type="checkbox"/> housing issue                         | <input type="checkbox"/> sleep: increase/decrease              |
| <input type="checkbox"/> developmental delay         | <input type="checkbox"/> marriage problems                     | <input type="checkbox"/> substance use: drugs/alcohol          |
| <input type="checkbox"/> disorientation              | <input type="checkbox"/> memory changes:<br>recent/progressive | <input type="checkbox"/> uncooperative                         |
| <input type="checkbox"/> disturbances in thought     | <input type="checkbox"/> mood changes                          | <input type="checkbox"/> weight: gain/loss                     |
| <input type="checkbox"/> energy: increase/decrease   | <input type="checkbox"/> obsessions, compulsions               | <input type="checkbox"/> Are you a risk to others/self?        |
| <input type="checkbox"/> family pressure             | <input type="checkbox"/> past suicide attempts                 |  |
| <input type="checkbox"/> feelings of hopelessness    |  |  |

How have the symptoms, if at all, impacted your daily living? (e.g. work, social, self-care, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**DIAGNOSIS:** additional information: duration, precipitating events, symptom details, other symptoms)

\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Which services are currently used?:

- |   |  |
|---|--|
| <input type="checkbox"/> ABEL Enterprises                       | <input type="checkbox"/> HADC - Haldimand Association of<br>Developmentally Challenged |
| <input type="checkbox"/> Adult Mental Health Services           | <input type="checkbox"/> Haldimand-Norfolk Resource Centre                             |
| <input type="checkbox"/> Assertive Community Treatment Team     | <input type="checkbox"/> Home Care (CCAC)  |
| <input type="checkbox"/> Alzheimer's Society                    | <input type="checkbox"/> Norfolk Association of Community Living                       |
| <input type="checkbox"/> Canadian Mental Health Association/H-N | <input type="checkbox"/> Private psychiatrist/psychologist/Counselor<br>Name: _____    |
| <input type="checkbox"/> Children's Aid Society                 | <input type="checkbox"/> Psychiatric Hospital _____                                    |
| <input type="checkbox"/> Community Access Support Services      | <input type="checkbox"/> REACH   |
| <input type="checkbox"/> Community Integration Worker           | <input type="checkbox"/> Regional MH London Community Liaison Nurse                    |
| <input type="checkbox"/> Community Support Program - ENSH       | <input type="checkbox"/> Seniors: Support Services                                     |
| <input type="checkbox"/> Employee Assistance Program            | <input type="checkbox"/> True Experience   |
| <input type="checkbox"/> Erie's North Shore Housing             | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Family Doctor: date last visit: _____  |  |
| <input type="checkbox"/> Friendly visitor                       |  |

**For which of the following service(s) is the referral made?**

- ABEL Enterprises - *work skills training, supported employment; business development*
- Adult Mental Health Services - *assessment; consultation; treatment; support; advocacy; counselling*
  - Referral seeking to switch from private psychiatrist to AMHS services
- Assertive Community Treatment Team - *intensive case management; community-based clinical service*
- Canadian Mental Health Association - *education; support group/workshop information; volunteer program*
- Community Support Program - *case management; support in Haldimand & Norfolk Counties*
- Erie's North Shore Housing - *housing for people with psychiatric problems in the Simcoe area*
- Specialized Geriatric Services - *specialized geriatric Assessment; Consultation; Treatment; Education*
- Regional MH London Community Liaison Nurse (formerly London Psychiatric Hospital)
- Haldimand-Norfolk Resource Centre - *peer support; recreational activities; education; advocacy*
- True Experience - *housing and work skills training in the Dunnville area*

**Service Preferences; if any:**

- Best Time to Call: \_\_\_\_\_
- Language: \_\_\_\_\_  Wheelchair Accessibility
- Location: \_\_\_\_\_  Other: \_\_\_\_\_

**CONSENT TO DISCLOSURE**

I, \_\_\_\_\_ hereby consent to the disclosure or transmittal of information to:  
(name)

(please check the appropriate program to which you are giving consent, cross out those that don't apply)

- ABEL Enterprises
- Adult Mental Health Services of H/N
- Assertive Community Treatment Team
- Canadian Mental Health Association/H-N
- Community Support Program
- Erie's North Shore Housing
- Specialized Geriatric Services
- Regional Mental Health London Community Liaison Nurse
- Resource Centre
- True Experience

I understand that non-identifying information may be collected from this referral for statistical purposes.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(note: client or legal substitute decision maker signature is necessary to process this referral.)

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Referring Source:** (please print) \_\_\_\_\_

**Referring Source Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please mail or fax to:**

**ADULT MENTAL HEALTH SERVICES OF H-N**

216 West Street, Suite 103  
SIMCOE, Ontario N3Y 1S8  
Fax: (519) 426-3257

OR

26 Main St. North, Box 760  
HAGERSVILLE, Ontario N0A 1H0  
Fax: (905) 768-5804

**For Assistance with the Form Phone: 1-877-909-4357 (HELP)**