Canadian Mental
Health Association
Brant-Haldimand-Norfolk

# Referral

Name ________________________________ Date of Birth (mm/dd/yy) ______________ Gender________

Address_____________________ Town/City_____________ Postal Code__________ ☐ Living Alone

Telephone _______________________ (alternate phone) _____________________ ☐ No Phone

Health Card Number ____________________________Version Code _____

Family Doctor: ___________________________

Psychiatrist: ______________________________ Expected date of discharge: __________________

**Primary symptoms and presenting issues:**

______________________________________________________________________________

______________________________________________________________________________

**What help or support is requested from CMHA:**

______________________________________________________________________________

______________________________________________________________________________

**Mental Health Diagnosis?** Is this diagnosis confirmed by a doctor? Yes ☐ No ☐

______________________________________________________________________________

**Current Medications:** ____________________________________________________________

______________________________________________________________________________

**Are there other community services presently involved?**

______________________________________________________________________________

Referring Source (PRINT name/agency) ________________________________ Contact #: _______________

**IMPORTANT:** If the applicant has not signed this form, they MUST be aware and consenting to this referral.

Referring Source Signature: __________________________________ Date: ___________________

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I understand that non-identifying information may be collected from this referral for statistical purposes.
I also understand that CMHA may try to contact me through my referring source should it be necessary. I am aware of - and consent to - this referral for support.

Applicant Signature: __________________________________________ Date: ___________________

**Please see other side for contact information** →

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## Give us a call. We can help.

**Toll Free:** 1-888-750-7778

**Website:** bhn.cmha.ca

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