



Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ Town/City \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ (alternate) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Email Only       No Phone       Messages OK       Text Only

Health Card Number \_\_\_\_\_ Version Code \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Psychiatrist: \_\_\_\_\_

Expected date of discharge or availability (if applicable): \_\_\_\_\_

Any active criminal Charges or involvement with Probation & Parole  \_\_\_\_\_

**Primary symptoms and presenting issues:** \_\_\_\_\_

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

**What help or support are you requesting from CMHA:** \_\_\_\_\_

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

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

\_\_\_\_\_

**Current Medications (optional):** \_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_

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: \_\_\_\_\_



## Who Can Apply for Services?

Referrals to CMHA, Brant-Haldimand-Norfolk Branch services can be submitted for any individual 16 years of age or older.

### Referrals can be made by:

- the individuals themselves (self-referral)
- family or friends
- physicians or psychiatrists
- social workers
- community support workers
- hospitals
- community agencies
- Legal Counsel and Crown Attorneys

**IMPORTANT:** The applicant **MUST** be aware and consenting to this referral

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## Give us a call. We can help.

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

**Website:** [bhn.cmha.ca](http://bhn.cmha.ca)

**E-mail:** [mail@cmhabhn.ca](mailto:mail@cmhabhn.ca)

### **Brant Office (Administration)**

44 King Street, Suite 203  
Brantford, Ontario N3T 3C7  
Tel: (519) 752-2998  
Fax: (519) 752-2717

### **Haldimand-Norfolk Office**

395 Queensway West  
Simcoe, Ontario N3Y 2N4  
Tel: (519) 428-2380  
Fax: (519) 428-3424