



CMHA Haldimand – Norfolk Branch  
**Referral Form**

Name \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_ Male/Female

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

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

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

Family Doctor: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**Symptoms and Other Issues:** (Please check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> angry, irritable, agitated  | <input type="checkbox"/> learning difficulties     | <input type="checkbox"/> physical disability          |
| <input type="checkbox"/> anxiety, panic              | <input type="checkbox"/> money problems            | <input type="checkbox"/> paranoia                     |
| <input type="checkbox"/> appetite: increase/decrease | <input type="checkbox"/> guilt                     | <input type="checkbox"/> trouble reading / writing    |
| <input type="checkbox"/> mood changes                | <input type="checkbox"/> hallucinations            | <input type="checkbox"/> poor judgement               |
| <input type="checkbox"/> current suicidal thoughts   | <input type="checkbox"/> hearing/visual impairment | <input type="checkbox"/> sadness                      |
| <input type="checkbox"/> past suicide attempts       | <input type="checkbox"/> housing issue             | <input type="checkbox"/> physical health issue        |
| <input type="checkbox"/> relationship/family issues  | <input type="checkbox"/> sleep: increase/decrease  | <input type="checkbox"/> feelings of hopelessness     |
| <input type="checkbox"/> disorientation              | <input type="checkbox"/> changes in memory         | <input type="checkbox"/> substance use: drugs/alcohol |
| <input type="checkbox"/> disturbances in thought     | <input type="checkbox"/> energy: increase/decrease | <input type="checkbox"/> weight: gain/loss            |
| <input type="checkbox"/> other _____                 |  |   |

**Describe what kind of help or support you would like from CMHA:**

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

**What is your mental health Diagnosis?** (if known)

\_\_\_\_\_

Is this diagnosis confirmed by your doctor? Yes  No

Are there any other stressors or current events that are affecting you right now?

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

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

\_\_\_\_\_

**For which of the following service(s) is this referral being made?** (check all that apply)

- Community Support Services (Case Management)
- Court Support Services / Mental Health Diversion
- Non Profit Housing / Transitional Bed Program
- Crisis Stabilization Bed Program

**Please complete other side** →



CANADIAN MENTAL  
HEALTH ASSOCIATION

ASSOCIATION CANADIENNE  
POUR LA SANTÉ MENTALE

**Which services do you presently use?**

- Abel Enterprises / Ace Program
- REACH \_\_\_\_\_
- Assertive Community Treatment Team
- Children's Aid Society
- Probation and/or Parole Services
- Senior Support Services
- Salvation Army Services \_\_\_\_\_
- Community Addiction & Mental Health Services  
Details: \_\_\_\_\_
- Vocational Supports \_\_\_\_\_
- Health Unit (specify): \_\_\_\_\_
- Haldimand-Norfolk Social Housing
- Brain Injury Services / Support
- True Experience
- NAACL / HADC / CLASS
- Haldimand-Norfolk Resource Centre
- Legal Aid / Legal Clinic
- CCAC
- Psychologist/Counsellor  
Name: \_\_\_\_\_
- Other CMHA Services
- Employee Assistance Program Services
- Food banks
- CAST (Crisis Assessment & Support Team)
- ODSP / OW
- Holmes House
- March Of Dimes
- Other \_\_\_\_\_

Any service delivery preferences or issues (ie: times available, language, accessibility, location, etc)?

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

I understand that non-identifying information may be collected from this referral for statistical purposes.  
I am aware of - and consent to - this referral for support.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Note: client or legal substitute decision maker signature is necessary to process this referral.)

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

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

Please return to: **Canadian Mental Health Association, Haldimand-Norfolk Branch**  
395 Queensway West,  
Simcoe, ON  
N3Y 2N4

E-mail: [info@cmha-hn.ca](mailto:info@cmha-hn.ca)  
Website: [www.cmha-hn.ca](http://www.cmha-hn.ca)

**Give us a call. We can help.**  
519-428-2380  
Or toll free 1-888-750-7778  
Fax: 519-428-3424