Canadian Mental Health Association
Cochrane-Timiskaming
Addiction and Mental Health Services

Association canadienne pour la santé mentale
Cochrane-Timiskaming
Services de toxicomanie et de santé mentale

CMHA-CT Recovery Centre

REFERRAL FORM

Program: ☐ **Bedded Addiction Treatment** ☐ **Bedded Withdrawal Management**	
Referral Date:	**Referring Source:**
Referring Agency:	**Contact Person:**
	Phone:
Select or outline which assessments/reports are included in this referral: ☐ ADAT ☐ GAINS Q3 ☐ GAIN-SS ☐ Blook Work ☐ Psychiatric Report ☐ Other:	

**This section must be completed. Please indicate if this is a self-referral*

Client Information

First Name:_____ **Middle Name:**_____

Last Name:_____ **Last Name at Birth:** _____

Preferred Name:_____ **D.O.B:** _____ **Age:** _____

Gender: ☐ Male ☐ Female ☐ Other ☐ Declined ☐ Unknown

Preferred Language: _____ **Francophone:** ☐ Y ☐ N

Health Card #: _____ **Indigenous and/or Metis:** ☐ Y ☐ N

Street Address: _____

Town: _____ **Province:** _____ **Postal Code:** _____

Home Phone: _____ OK to call ☐ Y ☐ N OK to Leave Message ☐ Y ☐ N

Cell Phone: _____ OK to call ☐ Y ☐ N OK to Leave Message ☐ Y ☐ N

Alternate Phone: _____ OK to call ☐ Y ☐ N OK to Leave Message ☐ Y ☐ N

Current Location (if different from above): _____

Email: _____

Substance Use History

Presenting Problem Substances (Drugs of Choice) / Frequency of Use:

_____

_____

_____

Last Date Substance Used: _____ **Substance(s):**_____

Previous Treatment: ☐ Y ☐ N **If yes, Where and When:** _____

_____

Medical/Health

Health Care Provider: _____ **Phone:** _____

Address: _____ **Fax:** _____

Current Pharmacy: _____ **Phone:** _____

Address: _____ **Fax:** _____

***Please include updated Medication Profile from Pharmacy with this referral.**

Disability: ☐ Visual ☐ Hearing ☐ Mobility ☐ Mobility **Pregnant:** ☐ Y ☐ N ☐ Unknown ☐ N/A

Health Conditions/Problems/Allergies: _____

_____

_____

Additional Information

_____

_____

_____

_____

_____

***Please attach any other relevant documents and assessments to this referral and send to:**

Canadian Mental Health Association – Cochrane Timiskaming
Attn: CMHA-CT Recovery Centre Program
31 Station Rd North PO Box 552
Kirkland Lake, ON P2N 2C7
Fax: 705-567-5211
RecoveryCentre@cmhact.ca

I, _____, consent to this referral.

☐ I provide consent to CMHA-CT to contact the source of this referral.

☐ I provide consent to CMHA-CT to contact my pharmacy and request a medication profile.

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above. • I understand that there are some circumstances in which this information may be re-disclosed to other parties and no longer protected by federal privacy laws. • I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission. • I have read all pages of this form and agree to the disclosures above from the types of sources listed.

Client Name/SDM: _____ **Signature:** _____

Date: _____

Witness Name: _____ **Witness Signature:**_____

Date: _____

***Substitute Decision Maker (SDM) must provide CMHA-CT with authorizing documentation.**