Canadian Mental Health Association
Association canadienne pour la santé mentale
GAMBLING, SUBSTANCE USE & MENTAL HEALTH SERVICES

CMHA
Referral Form for Nurse Practitioner Services

****** This is a <u>temporary service only</u>, all patients <u>MUST</u> register with Health Care Connect (information attached) in an effort to secure a permanent Primary Care Provider ******

HAS FAMILY PHYSICIAN OR NURSE PRACTITIONER IN SIMCOE COUNTY:

☐ **Yes**
****<u>If yes, then patient does not meet criteria for this service</u>***
☐ **No**

REGISTERED FOR HEALTH CARE CONNECT: ☐ **Yes** **or** ☐ **Will Complete**

CMHA Staff Use Only: ***Staff Name:*** **EMHWare #**

LEGAL NAME *(First & Last):*	**PREFERRED NAME *(If different from legal name):***
GENDER IDENTITY : **LEGAL GENDER:**	**D.O.B dd/mm/yyyy** ____/____/_____

ADDRESS *(Including postal code):*

TELEPHONE #: ***(Please check box where message may be left)***

☐ **Home:** ☐ **Other:**

*****<u>MUST have current or temporary card in order to be scheduled/seen</u>*****

HEALTH CARD NUMBER: __ __ __ __ __ __ __ __ __ __ __ __ **VERSION CODE:** __ __

PREFERRED PHARMACY: **TELEPHONE NUMBER:**

*****<u>MUST have pharmacy forward medication profile to Fax: 705-797-2035 prior to initial consult appointment</u>***

REASON(S) FOR REFERRAL TO THIS SERVICE:

HEALTH CONCERNS *(Please list):*

MEDICATIONS NEEDED *(Please list):*
*(*Narcotics &/or marijauna are <u>NOT</u> prescribed at this clinic)*

FORMS NEEDED *(Please list):*
*(*Allow 4 to 6 months for completion of forms, if psychiatric assessment is required it may take longer)*

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PREVIOUS HOSPITALIZATIONS IN LAST 5 YEARS: **WHERE:** **REASON:** **WHEN:**
PAST SURGICAL HISTORY:
PAST PSYCHIATRIC HISTORY/PSYCHIATRIST'S NAME:
PAST MEDICAL HISTORY:
DRUG/ALCOHOL USAGE:
PREVIOUS OR CURRENT INVOLVEMENT WITH OTHER MENTAL HEALTH SERVICE PROVIDERS: ☐ **Yes *(Please list):*** **or** ☐ **No**

Date of Referral: dd/mm/yyyy ___/___/____ Patient Signature: _____

Referral Source: _____

******PLEASE NOTE:******

In order to provide patient care in a timely manner the following documents are needed:

1. *Assessment/consultation from Psychiatrist or other mental health workers*
2. *Discharge summary from hospitalizations within 1 year*
3. *Any prior investigation such as CT scan, MRI, Ultrasounds, and X-rays especially if this is the reason for the visit*

EMAIL TO: pmoon@cmhastarttalking.ca **OR** **FAX TO: 705-797-2035**