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** or ☐ **No**

<u>If yes, then patient does not meet criteria for this service</u>

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

CMHA Staff Use Only:
Name Of CMHA SC Caseworker: **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:**

EMERGENCY CONTACT:

NAME: **RELATIONSHIP:** **TELEPHONE #:**

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

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

Date of Expiry dd/mm/yyyy ____/____/_______

PREFERRED PHARMACY: **TELEPHONE NUMBER:**

***<u>**MUST** have pharmacy forward medication profile to Fax: 705-725-0646 prior to initial consult appointment</u>*

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REASON(S) FOR REFERRAL TO THIS SERVICE:

HEALTH CONCERNS *(Please list):*

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

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

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: 705-725-0646