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

CMHA Referral for Nurse Practitioner Services

*****This is a <u>temporary service</u>, ALL patients <u>MUST</u> register with Health Care Connect in order to obtain a permanent Primary Health Care Provider *****

HAVE A FAMILY PHYSICIAN OR NURSE PRACTITIONER IN SIMCOE COUNTY: ☐ **Yes** or ☐ **No**

(If the answer is <u>YES</u>, then you do not meet the criteria for this service)

REGISTERED WITH HEALTH CARE CONNECT: ☐ **Yes**

1-800-445-1822

CMHA Staff Use Only

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):*

CONTACT # (permission assumed for messages to be left via voicemail and email correspondence)

HOME/CELL PHONE: **EMAIL:**

EMERGENCY CONTACT:

NAME: **NUMBER:**

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

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

Date of Expiry: dd / mm / yyyy ______/______/___________

PREFERRED PHARMACY: **TELEPHONE NUMBER:**

ALLERGIES:

REASON(S) FOR REFERRAL TO THIS SERVICE

HEALTH CONCERNS *(Please list):*

MEDICATIONS NEEDED *(Please list):*
*(*Narcotics &/or marijuana are <u>NOT</u> 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)*

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Are you involved in a lawsuit, insurance claim or ODSP application? Yes_____ No_____

PAST SURGICAL HISTORY:

PREVIOUS OR CURRENT PSYCHIATRIC HISTORY / PSYCHIATRIST'S NAME:

FAMILY HISTORY:

Family Member	Living (L) Deceased(D)	Medical Condition (diabetes, cancer, heart attack, stroke, genetic disorder, mental health, immune disorder, etc.)
Mother		
Father		
Brother(s)		
Sister(s)		

RECENT MEDICAL:

Have you been in walk-in clinic, emergency or admitted to hospital in the past two years? Yes___ No___

If Yes, explain:

Initial, Permission to collect records: __________

Specialist Physicians:

Initial, Permission to collect records: ________

LIFESTYLE:

Physical Activity: Low_______ Moderate_________ High_________ Needs Improvement__________

Nutrition Needs: Accessing food bank__________ Nutrition support needed? Yes____ No____

Caffeine # daily________ Alcohol # daily____________ Cannabis grams daily_________

Addiction support needed? Yes____ No____

Tobacco use: Smoker____ Non-smoker____ Smoking cessation resources needed? Yes____ No____

PREVIOUS OR CURRENT INVOLVEMENT WITH OTHER MENTAL HEALTH SERVICE PROVIDERS:

☐ **Yes *(Please list):*** ☐ **No**

Date of Referral: dd/mm/yyyy _____/_____/________ Patient Signature: _________________________________

Referral Source: ____

*****FAX Referral Form and Relevant Documentation to 705-725-0646*****