

CMHA Mental Health First Response Team Request for Services

 \* Is the individual aware that a request for service is being made? [ ]  **Yes** [ ] **No**

Is this a d/c referral from hospital - [ ]  **Yes** [ ]  **No**

**Section A: Service Request Information and Presenting Issues**

Date: (DD/MM/YY) Referral Time:

Referral Source: Self [ ]  PCP [ ]  Psychiatrist [ ]  Other [ ] ***(Please Specify)***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Provider’s Name: 

Mental Health Diagnosis:

Medications:

Describe Mental Health and/or Physical Health Concern:

Identify areas of risk or concern relevant to this individual or home environment:

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**Section B: Personal Information**

Client Name: Gender: [ ]  Male [ ]  Female [ ]  Trans

Date of Birth: (DD/MM/YYYY) Age: Health Card:

Address: City: Postal Code:

Phone # 1: Okay to leave message ☐Yes ☐No

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code:

Phone # Okay to leave message ☐Yes ☐No

**Section C: Additional Information**

Referral Outcome:

Worker Contact:

**Fax completed form to:** **Chatham (519) 351-9203 or Sarnia (519) 337-2325 \*A CMHA First Response Team Member will respond as soon as possible, but no later than 1 business day; and an assessment will be completed.**