Canadian Mental Health Association
Lambton Kent

Single Point Access For CMHA Referrals
Sarnia Lambton Site

Please attach any additional assessments or information.

Referral Source Information:

Date: _____ (DD/MM/YY) Referral Time: _____ **(24 hour time system)**

Referral Source: ☐ Psychiatrist ☐ Primary Care Practitioner ☐ Other

Referral from: _____ CPSO # if applicable: _____

(***Please print)***

Referral contact information:

_____

Has this person been discharged from hospital in the past 48 hours? Yes ☐ No ☐

Was this hospitalization for a suicide attempt or suicidal ideation? Yes ☐ No ☐

Please describe any relevant mental health issues/reason for referral:

_____

_____

Please identify any other areas of risk/concern that CMHA should be made aware of:

_____

_____

Is this person aware of CMHA referral being made: Yes ☐ No ☐

Personal Information:

Legal Name: _____ Pronoun: _____

Preferred Name: _____ Preferred language: ☐ English ☐ French

Indigenous preferred worker or support person, (if available): ☐ Yes ☐ No

D.O.B. _____ (DD/MM/YYYY) Health Card #: _____ Version Code _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Okay to leave message: Yes ☐ No ☐

Emergency Contact Name: _____ Phone: _____

SDM or POA: _____ Relationship: _____ Phone: _____

Office Use Only:

Referral Outcome: _____

CMHA Worker Contact:

Fax completed form to Sarnia CMHA (519) 337-2325

CMHA Team Member will respond within two business days.

Updated: July 2022