WOTCH COMMUNITY MENTAL HEALTH SERVICES
NORTH – EXETER/GODERICH

INTAKE REFERRAL FORM

REFERRAL SOURCE CONTACT INFORMATION

Referred by (please print name:) ______________________ Date of Referral: __________
mm / dd / yy

Agency/Area: ______________________ Phone & ext: __________

Fax: ______________________ Email address: __________

CLIENT INFORMATION

Name of Client (please print): ______________________

D.O.B. __________ Gender: __________ Marital Status __________

Address: ______________________

City: __________ Postal Code: __________ Phone: __________

Health Card Number: ______________________

Income Source: ______________________

Highest level of education completed:

Okay to leave message? ☐ **yes** ☐ **no**

KEY SUPPORTS (consents required for contact)

Name of emergency contact person: ______________________

Address: ______________________ Phone: __________

Relationship to client: ______________________

Next of Kin (if different from emergency contact): ______________________

Address: ______________________

City: __________ Postal Code: __________ Phone: __________

LANGUAGE AND CULTURE

Communication Barriers: ______________________

Preferred Language: ______________________

Aboriginal: ☐ yes ☐ no ☐ unknown

Citizenship/Current Immigration Status: ______________________

CLIENT NAME: DATE OF BIRTH:

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HEALTH

		Confirmed By	Date
Axis I Diagnosis			
Axis II Diagnosis			
Axis III Diagnosis			
Allergies			
Physical Disability			

Smoker: ☐ yes ☐ no

Medications	Dose	Frequency

Please attach an additional sheet if more space is needed to complete Medications portion.

Is client currently in hospital: ☐ yes ☐ no Date of Admission: ______________

Most recent hospitalization: ______________ Length of Stay: ______________

Hospital Name: ______________ Number of Hospitalizations in last 2 years: ______

HEALTH SYSTEM SUPPORTS

Psychiatrist: ______________ Phone: ______________

Address: ______________

Family Physician: ______________ Phone: ______________

Address: ______________

Other: ______________

Has the client been involved with Mental Health and addiction Services in the past: ☐ yes ☐ no

Details of involvement: ______________

CLIENT NAME: DATE OF BIRTH:

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ASSESSMENT INFORMATION *(please attach copies)*

Camberwell ☐ Psychiatric assessment ☐ Psychosocial assessment ☐ OT assessment ☐

Other *(Specify)*:

RISK FACTORS *(if “Yes” please provide date and details)*

Abuses alcohol or drugs (non-prescription or prescription) ☐ yes ☐ no ☐ unknown

Details of substance misuse: ____________________

Receives treatment for drugs or alcohol ☐ yes ☐ no ☐ unknown

Details of treatment *(include date(s)):* ____________________

Recent or past involvement with Police? ☐ yes ☐ no ☐ unknown

Details of Police Involvement *(include date(s)):* ____________________

Currently on Probation/Parole? ☐ yes ☐ no ☐ unknown

Details of Probation/Parole (include date): ____________________

Self Abuse? ☐ yes ☐ no ☐ unknown

Details of Self Abuse (include date(s)): ____________________

Physical Abuse/Aggression to Others? ☐ yes ☐ no ☐ unknown

Details of Abuse/Aggression (include date(s)): ____________________

Has client damaged property? ☐ yes ☐ no ☐ unknown

Details of Property Damage (include date(s)): ____________________

Suicide Attempts? ☐ yes ☐ no ☐ unknown

Details of Suicide A (include date(s)): ____________________

Communicable Diseases? ☐ yes ☐ no ☐ unknown

Details of communicable disease (include date(s)): ____________________

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Currently describes self in crisis? ☐ yes ☐ no ☐ unknown

Details of current crisis: ______________________________

If available please attach a copy of client's crisis plan.

Does the client live with an abusive partner, roommate or family member? ☐ yes ☐ no ☐ unknown

If yes, please provide details: ______________________________

Does the client have pets in the home? ☐ yes ☐ no ☐ unknown

If yes, please specify: ______________________________

Are there any other known or potential risk factors not identified above? ☐ yes ☐ no ☐ unknown

If yes, please provide details: ______________________________

What are the client's strengths? ______________________________

Is there any other information that might be useful: ______________________________

For what issues is the client being referred for community mental health services?

☐ Mental Health Symptoms	☐ ADL's	☐ Housing
☐ Addictions	☐ Financial	☐ Employment / Education
☐ Physical Health	☐ Relationships	☐ Leisure / Recreation
☐ Legal	☐ Other:	

CLIENT NAME:		DATE OF BIRTH:	

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Client's Recovery Goals:

CLIENT NAME:		DATE OF BIRTH:	