Health PEI

Clear Form

COMMUNITY MENTAL HEALTH & ADDICTIONS – REFERRAL FORM (ALL AGES)

Please complete both sides of this form. *Be advised that after receiving this referral, Community MH&A will contact the client to complete an intake assessment to identify the most appropriate stage-matched service option.*

Service Requested	Community Locations & Fax Numbers
☐ Community Mental Health Services	Community Mental Health – Charlottetown……902-368-4427 Community Addictions Services – Charlottetown……833-696-0813 Community Mental Health – McGill Centre……902-368-6189 Community Mental Health – Summerside……902-888-8173 Community Addictions Services – Summerside……902-432-2585 Community Mental Health & Addictions – Alberton……902-853-0420 Community Mental Health & Addictions – Montague……902-838-0961 Community Mental Health & Addictions – Souris……902-687-7119
☐ Community Addictions Services	

Referral Source Information		
Date of Referral:	**Please confirm that client is aware of this referral and has agreed to participate in an intake assessment: ☐ Yes**	
Referred by/Name:	Agency/Organization:	Telephone #:
Client Information		
Legal Name:	Preferred Name:	Gender:
PHN:	Date of Birth:	Email Address:
Address (mailing & civic):		
Preferred Telephone #: ☐ Cell ☐ Home ☐ Work	Hospital Discharge Date: (if applicable)	
Primary Care Provider:	Psychiatrist: (if applicable)	
Alternative Contact		
Name:	Telephone #:	
Parent/Guardian Information (for clients under 18 who have consented to parent involvement with this referral)		
Name(s):	Telephone #(s):	Custody Status:
Public Guardian or Public Trustee Information (if applicable)		
Public Guardian Name:	Telephone #:	
Public Trustee Name:	Telephone #:	

Client Presentation	
Presenting concerns & relevant information:	
Duration of current difficulties:	☐ < 1 month ☐ 1-6 months ☐ 6-12 months ☐ > 1 year
Environments impacted:	☐Home ☐Work ☐School ☐In the community ☐Other:
Physical illnesses or chronic medical conditions (if applicable):	
Current medications (if applicable):	

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Substance Use		
Select all that apply		*Details*
Alcohol		
Cannabis		
Opiates		
Other		

Safety		
Select all that apply		*Details*
Previous suicide attempt		
Current suicidal ideation		
Current plan		
Self-injurious behaviour		
Risk of harm to others		

Life Stressors		
Select all that apply		*Details*
Experience of abuse		
Person who has been abusive		
Recent separation/divorce		
Grief/Losses		
Financial-related		
Legal involvement		
Other		

Symptoms			
Select all that apply			*Details*
Affective Symptoms	Anxiety		
	Low mood		
	Elevated mood		
	Sleep changes		
	Appetite/Weight changes		
	Food restriction/Bingeing/Purging		
	Repetitive actions or behaviours		
	Concentration difficulty		
	Low energy		
	Loss of interest		
	Other		
Psychosis Symptoms	Hallucinations		
	Paranoia		
	Delusions		
	Other		
Cognitive Symptoms	Cognitive impairment		
	Developmental disability		
	Intellectual disability		
	Learning disability		
	Other		
Social Symptoms	Decline in self-care/hygiene		
	Social withdrawal/isolation		
	Impulse control difficulties		
	Other		