Adult Psychiatric Assessment/ Mental Health Counselling Referral

First Name: _____ **Last Name:** _____

DOB: _____ **Age:** _____ **Gender:** _____
DD MM YYYY

Marital Status:
Single ☐ **Common-law** ☐ **Divorced** ☐ **Widowed** ☐ **Married** ☐ **Separated** ☐

HC #: _____ **Version Code** _____ **Expiry Date:** _____

Street Address: _____ **Box #:** _____

Town: _____ **Home Phone #:** _____ **May leave message: Y** ☐ **N** ☐

Cell Phone #: _____ **Work Phone:** _____

Contact at Home? **Yes** ☐ **No** ☐ **Preferred Language:** **English** ☐ **French** ☐

PHYSICIAN / HEALTH CARE PROVIDER: _____ **None:** ☐

REFERRED BY: _____ **REFERRAL DATE:** _____

PHONE #: _____ **EXT:** _____ **FAX #:** _____

Is client at risk of self-harm? Y ☐ **N** ☐ **Harm to others: Y** ☐ **N** ☐ **Past/present hx violence: Y** ☐ **N** ☐

Services	Service Required	Brief history & Request
Psychiatric Assessment Services	☐ **Psychiatric Assessment** ☐ **Physician to Psychiatrist phone/OTN consult. Client must be registered with NOSP**	*(check all that apply)* **Anxiety Related:** ☐ **Mood:** ☐ **Life Event:** ☐ **Thoughts/Psychosis:** ☐ **Substance Related:** ☐ **Other:** _____ **Brief History:**
Counselling	☐ **Mental Health** ☐ **Therapy** ☐ **Short-term/brief support** ☐ **Intensive (crisis/safety planning response)** ☐ **Addictions** ☐ **Rental Supplement/Support Program*** ☐ **Other**	
Seniors Support & Services	☐ **Mental Health** ☐ **Cognitive assessments** ☐ **Counselling/intervention** ☐ **Family Support** ☐ **Senior Volunteer in Service**	
Brief Service	☐ **Emergency/Clinic Visit Follow Up (mental health/addictions)**	

Current medication (attach list): Yes ☐ **NO** ☐ **CLIENT AWARE OF REFERRAL: YES** ☐ **NO** ☐

***please complete the additional Rental Supplement/Support Program Initial Referral Screening Form**

FAX REFERRAL TO NOSP OFFICE: Geraldton/Longlac: 807-854-0006 Nipigon/Red Rock: 807-887-2764
Schreiber/Terrace Bay: 807-824-1121 Marathon: 807-229-3040 Manitouwadge: 807-826-3088 (September 2017)