Working together to optimize health and well-being.

North of Superior Counselling Programs Referral

FAX COMPLETED REFERRAL TO NOSP OFFICE: Greenstone: (807) 854-0006 Armstrong/Nipigon: (807) 887-2764
Schreiber/Terrace Bay: (807) 824-1121 Marathon/Manitouwadge: (807) 229-3040

First name:	Last name:		
DOB: (yyyy/mm/dd)	Gender:		Age:
Health Card:	Version:	Expiry date:	
Street address:	P.O. Box #:	Town:	Postal code:
Name of parent / legal guardian (applicable youth <12 years old):			
Home phone #:	Cell phone #:		
Email:			

Required for Referral			
	May we leave a message?	☐ Y	☐ N
	May we mail information?	☐ Y	☐ N
	May we text or email scheduling appointments?	☐ Y	☐ N

Preferred language:	☐ English	☐ French	☐ Other:
Current school / daycare (if applicable)			Grade:
Are Child Protection Services involved? ☐ Y ☐ N	If yes, which Agency?		
Physician / Health Care Provider:			☐ none

REFERENT INFORMATION

Name of referent: ____ Referral date: ______________________ (yyyy/mm/dd)

Name of Organization / Agency: ____

Phone #: EXT: FAX:

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

Reason for Referral (please check) ☐ Mental Health counselling ☐ Substance/Addiction counselling

Please provide a brief summary of presenting issues:

ADULT SPECIALTY SERVICES (please check)	Current medication list attached: ☐ Y ☐ N
☐ Psychiatry & counselling ☐ Psychiatry only ☐ Physican-Psychiatrist consult (must be a client of NOSP) ☐ **Housing RSSP*** ☐ Senior Support	Referred client or legal guardian has provided verbal consent for referral? ☐ Y ☐ N

* **please complete the additional Rental Supplement/ Support Program (RSSP) Initial Referral Screen Form**