M'Chigeeng Health Services
Mental Health & Addictions (MHA) Clinic
Referral Form

Date of Referral: _____ (DD/MM/YYYY)

Must have Client's Verbal or Written Consent to Continue with Referral Form.

CLIENT CONTACT INFORMATION:	
<u> if client is in CRISIS, please call 1-877-841-1101 or emergency services at 911. **</u>**	
Legal Name:	Preferred Name:
Gender:	Pronouns:
D.O.B. (DD/MM/YY): Age:	Health Card # (& version code):
Mobile Phone:	Is it safe to leave a voicemail? (yes/no):
Alternative Phone:	Is it safe to leave a voicemail? (yes/no):
e-mail address: is it safe to send a message? (yes/no)	Preferred Contact Method (phone, email):
911 Address:	PO Box #
Community or Band Member (status #):	Emergency Contact Name: (or SDM & number)
Emergency Contact Phone:	Emergency Contact Relationship:

REFERRAL INFORMATION:			
Reason for Referral:		Additional Information:	
☐ Self	☐ Hospital	☐ Internal	☐ External
Referral Contact & Agency:		Contact Phone Number:	

SERVICE(S) BEING REQUESTED:	
☐ MHA Counselling – Adult (18+)	☐ MHA Counselling – Child & Youth (6-17)
☐ Systems Navigator	☐ Wellness Recovery Program (Addiction Meds)
☐ Detox or Treatment Referral	☐ Traditional Health Referral
☐ STBBI Case Management/Peer Support	☐ STBBI Mental Health & Addiction Nurse

FOR CLINICIAN USE: Check one: Urgent ☐ Routine ☐	
Clinician Assigned:	Date Received:
1st Contact date/time:	2nd Contact date/time:
3rd Contact date/time:	Referral Closed date/time:

Clinician Signature: _____ Date Assigned (DD/MM/YYYY): _____

Send completed referral to MFN Health Centre's Confidential Fax (705) 377-5547 or Email: mhaintake@mchigeeng.ca