CAMPBELLFORD MEMORIAL HOSPITAL

CAMPBELLFORD MEMORIAL HOSPITAL COMMUNITY MENTAL HEALTH CENTRE

146 Oliver Road
Campbellford, ON K0L 1L0
Phone (705) 632-2015
Fax (705) 653-0436
e-mail: wellness@cmh.ca

REFERRAL FORM

- **Please fax the completed referral to 705-653-0436.**
- **Our program will make two attempts to contact the client and if not successful a letter will be mailed to them. If they do not respond in 10 business days of the letter being sent, the file will be closed.**
- **Referrals to psychiatry must be completed by a Physician or Nurse Practitioner.**

REFERRING PROVIDER

First Name: _____ Last Name_____ Billing Number: _____

Phone: _____ Fax: _____

Family Physician if different from Referring

First Name: _____ Last Name_____

Patient Information

First Name: _____ Last Name_____

DOB: _____ Health Card: _____ Version Code_____

Address: _____

Patient Phone: _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Alternate Phone_____ ☐ Home ☐ Cell ☐ Work ☐ Other

Service Requested

☐ Counselling & Treatment
6-8 sessions to discuss emotional issues, and coping strategies with goal setting.

☐ Case Management
To stabilize and achieve goals to improve quality of life, advocacy, and service coordination

☐ Early Psychosis Invention Program
Offers assessment, treatment support and education, specifically for people ages 14- 35 who are experiencing the early stages of psychosis

☐ Court Support
Assistance to Individuals with Mental Health difficulties who have criminal charges that were laid in Northumberland County.

☐ Psychiatric Consultation ☐ Urgent ☐ Elective
Psychiatry consultation for diagnostic clarification, treatment recommendations and medication review. Follow up will be to the psychiatrist discretion.

☐ Crisis Support
Our Crisis worker is available Monday-Friday 8:30-4:00pm.

#300-001-02-15 (revised June 2023)

REASON FOR REFERRAL

Mental Illness Diagnosis: _____

Contributing Factors
Please check any that apply to the patient

☐ Anger Control	☐ Homeless	☐ Loss of appetite	☐ Loneliness
☐ Decision Making	☐ Trauma - Physical Abuse	☐ Suicidal thoughts	☐ Loss of interest
☐ Hoarding	☐ Trauma - Sexual Abuse	☐ Anxiety	☐ low energy/Low motivation
☐ Irritability	☐ Trauma -Emotional Abuse	☐ Delusions	☐ Paranoia
☐ Loss/grieving	☐ Trauma - other	☐ Hallucinations (Auditory)	☐ poor concentration
☐ Memory problems	☐ Disorganized	☐ Hallucinations (Smells)	☐ Racing thoughts
☐ Problem Solving	☐ Disorganized Speech	☐ Hallucinations (touch)	☐ Substance Use
☐ Sleep Disturbance	☐ Disorganized Thoughts	☐ Hallucinations (visual)	☐ Cries easily
☐ Hopelessness	☐ Sadness/depressed	☐ Isolation	☐ Legal

Risk Assessment (If you checked yes to any below, please provide information)

Suicidal Thoughts ☐ Yes ☐ No Does the patient have a plan ☐ Yes ☐ No Past Suicide Attempts ☐ Yes ☐ No

Domestic Violence
☐ Yes ☐ No

Aggressive Behaviour
☐ Yes ☐ No

Current Criminal Charges
☐ Yes ☐ No

Current/Past Medication(s)/Dosage