



**SOUTHWEST ONTARIO ABORIGINAL HEALTH
ACCESS CENTRE**

* GANAAN DE WE O DIS * ^YETHI YENAHWAHSE *
425-427 William Street, London, ON N6B 3E1
519-672-4079 or Toll Free 1-877-672-4079

Mental Health/ Crisis Program Referral Form

Client Information

Full Name (Print): _____ Date: _____
(mm/dd/yyyy)

Address: _____

City and Postal Code: _____

Telephone Number(s): _____

Date of Birth: Month _____ Day _____ Year _____ Age= _____ Male Female

Health Card Number: _____ Version Code: _____

First Nation (if applicable): _____

Status Card Number (if applicable): _____

Referral Source: (Please complete if this is not a self-referral)

First Name: _____ Last Name: _____

Agency and Title/Position: _____

Agency Address: _____

Agency Phone: _____ Fax: _____

Referral Discussed with applicant? Yes No

If "No" please explain: _____

Release Form Attached: Yes No

Emergency Contact Person

Name of Contact Person/Relationship: _____

Address & Phone Number: _____

Mental Health Information

Mental Health Diagnosis/Date: _____

Doctor Making Diagnosis: _____

Physical Disability or Chronic Health condition: _____

Medications List: _____

Date/Location of Most Recent Hospitalization: _____

Client Name: _____	D.O.B: _____
Health System and Agency Supports	

Family Physician: _____ Ph# _____

Psychiatrist: _____ Ph# _____

Other Supports: Please name agency, worker & phone number: (i.e. N'Amerind, At'lohssa, CAS, WOTCH,...) _____

Risk Factors

Alcohol or drug abuse (non-prescription or prescription) Yes No Unknown

Receives treatment for drugs or alcohol? Yes No Unknown

Recent or past involvement with police? Yes No Unknown

Currently on parole or probation? Yes No Unknown

Self –Abuse? Yes No Unknown

Physical Abuse or Aggression/Others (past or present)? Yes No Unknown

Suicide Attempts? Yes No Unknown

Does the client describe self in crisis? Yes No Unknown

If “yes”, describe current crisis: _____

Wellness Factors

Residential School Impact? Yes, a parent/guardian Yes, self No Unknown

Community (Aboriginal) Involvement? Yes No Unknown

Participates in Spiritual and/or Cultural practices? Yes No Unknown

Contact with family? Yes No Unknown

Reason for Referral

Address the following issue(s): mental health symptoms relationships crisis

addiction housing/financial employment/education court/legal/CAS

grief/loss stress or anger management Other _____

***Fax Completed Form to: SOAHAC Mental Health/Crisis Coordinator 519-672-7220**
***Referral Source will be contacted within one week of receiving this Form.**