Community Addiction and Mental Health Services
Services communautaires de santé mentale et de dépendances

COMMUNITY ADDICTION AND MENTAL HEALTH SERVICES
Cornwall Community Hospital
For Stormont, Dundas, Glengarry & Akwesasne

This form is for non-urgent referrals: if you require urgent mental health care contact the Distress Centre at 1-866-996-0991
For active withdrawal symptoms please contact Community Withdrawal Management Services (Cornwall) at 613-938-8506

Language Preference ☐ English ☐ French Is a translator required, if so what language?

1. Client Information

Last Name | First Name | Preferred Name | Date of Birth (mm/dd/yy)

Health Card Number & Version Code/Aboriginal Band # | Gender | Marital Status | Ethnicity

Address | City | Province | Postal Code

Phone #: Home_____ Permission to leave a Message: Yes No
Work _____ Permission to leave a Message: Yes No
Cell: _____ Permission to leave a Message: Yes No
Alternate Contact (Relationship) Alternate Contact Telephone Number

2. Reason for Referral - Presenting Problems & Symptoms

_____
_____
_____
_____
_____
_____

Mandated Treatment? ☐ Yes ☐ No By whom:
Psychiatric Diagnosis? ☐ Yes ☐ No ☐ Unknown
Current or Previous Mental Health Services

_____

3. Medications

_____
_____
Attach Current Medication List or provide name of Pharmacy:

4. Client Referral

Client has been made aware of referral?
☐ Yes ☐ No
If No, please explain:

5. Referral Source

Name:
Address:
Phone #:
Signature _____ Date _____

6. Family Physician/Nurse Practitioner:

Name:
Address:
Phone #:

COMPLETED REFERRAL FORM SHOULD BE RETURNED TO:
850 McConnell Ave, Cornwall, ON K6H 4M3 **Phone: 613-361-6363 Fax: 613-361-6364**

Revised date: December 12, 2016