

Referral Information (complete those sections not entered on CMHA referral form)

Client Name: _____ Client Number: _____
 Phone Number: _____ Alternate Number: _____
 Instructions for Contacting Client: _____
 Emergency Contact (include Phone #): _____
 Date of Birth (mm/dd/yy) _____ Today's Date: _____
 Marital Status (Check one) Single Married Separated Divorced/Widowed
 Address: _____
 Psychiatrist: _____
 Last visit to Primary Care Provider: _____ Name: _____
 CMHA Client? (Check one): Yes No
 Referred by (worker name and extension) : _____
 Type of Referral Telephone Walk in

CRITERIA

- Do not have a family doctor at the time of presentation to the City Centre Health Care*
AND
- Live in the catchment area bounded by Crawford Ave; Tecumseh Rd; Central Ave and Riverside Drive (Provide an address that is within this catchment area in order to receive service from the NP or MD)
OR
- No Family Doctor and have a diagnosis of serious mental illness (SMI) living anywhere in Windsor and Essex County
OR
- Presently have a Family Doctor (Will be considered but at a lower priority)
- None of the above criteria met

Referral Prioritization Tool (check)

<input type="checkbox"/> SMI	<input type="checkbox"/> Non-SMI
<input type="checkbox"/> No Family Doctor and needs psychiatrist / therapy	<input type="checkbox"/> No Family Doctor
<input type="checkbox"/> Discharge from Hospital with no Family Doctor	<input type="checkbox"/> Single Parent / Children / Pregnant

Recent Hospitalization: (reason and dates)

Reason for Referral: Urgent Yes or No (If yes- list reason for urgent referral)

Allergies: _____

****Please List all Medications : (Bring all medications, including herbals or over the counter to appointment, secured in a Ziploc/plastic bag)**

Past Medical History: (check all pertinent items)

<input type="checkbox"/>	Epilepsy (seizures/convulsions)	<input type="checkbox"/>	Anemia (low blood counts)	<input type="checkbox"/>	Street drugs
<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	Genetic Disease (born with disease)
<input type="checkbox"/>	Mental Illness (List Diagnosis)	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Cancer (type)
<input type="checkbox"/>	Glaucoma or Eye problems	<input type="checkbox"/>	Osteoporosis (weak bones)	<input type="checkbox"/>	Skin Problems (Eczema, Psoriasis)
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Motor vehicle accident
<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	Hay fever (seasonal allergies)	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Taking any pain medications/regular basis
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Fibromyalgia/chronic pain
<input type="checkbox"/>	COPD or Bronchitis (breathing problems)	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Liver problems (Hepatitis C)
				<input type="checkbox"/>	Kidney Problems