REFERRAL FORM

Send to: Mental Health and Addictions Services
36 Queensway, c/o 50 Union Street
Grand Falls-Windsor, NL A2A 2E1
OR Fax: (709) 489-8182
INCOMPLETE FORMS MAY DELAY PROCESSING

Current date: ______ MCP #: ______ MCP expiry date: ______

Client's name: ______ Date of birth: ______

First Middle Last Day Month Year

Mailing address: ______

Telephone (Home): ______ Work: ______ Cell phone: ______

Next of kin/Parent/Guardian (see * below): ______ Relationship: ______

*** If client is under 16 years of age, please ensure parent/guardian name is provided**

Telephone: ______ Mailing address: ______

Can we contact client by telephone? Yes ☐ No ☐ or by writing? Yes ☐ No ☐

Client may need assistance? (see ** below) Yes ☐ No ☐ Is client aware of the referral? Yes ☐ No ☐

** **If the person needs assistance in completing triage please indicate.**

Relevant history/observations (check all that apply)

☐ Alcohol issues	☐ Change in mood	☐ Physical health concerns
☐ Drug issues	☐ Socially isolated/withdrawn	☐ Difficulty functioning at home/school/work
☐ Gambling	☐ Loss of interest/motivation	☐ Pregnant or recent child birth
☐ Eating/Food related concerns	☐ Grief	☐ Risk to others/abusive behaviour
☐ Engaged in risky/abusive behaviour	☐ Self-harm/risk to self	☐ Separation/loss
☐ Change in sleep	☐ Excessive worry	☐ Change in memory/concentration
☐ Change in appetite	☐ Obsessions/compulsions	☐ Delusions/hallucinations

☐ Other: ______

Reason for referral: ______

Referral source signature: ______ Role: ______

Address: ______

Telephone: ______ Client signature: ______

Centralized Triage - Call toll free 1-844-353-3330

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