Print Form

# *REFERRAL FORM*

Send to: Mental Health and Addictions Services
James Paton Memorial Regional Health Centre
Gander, NL A1V 1P7
OR Fax: (709) 256-5667

***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| ☐ Drug issues | ☐ Socially isolated/withdrawn | ☐ Difficulty functioning at home/school/work |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