Canadian Mental Health Association
Nipissing Regional Branch
Mental health for all

Association canadienne pour la santé mentale
Filiale régionale de Nipissing
La santé mentale pour tous

CMHA Nipissing Trusteeship Referral

Please submit completed referrals to:
Bridges-CMHA Nipissing
156 McIntyre Street West
North Bay, ON P1B 2Y6
(705) 474-1299 Fax: (705) 474-5325

Name of Person Being Referred: _____ Date: _____
DD/MM/YYYY

Gender: _____ Date of Birth: _____ Age: _____
DD/MM/YYYY

Aboriginal Origin: Aboriginal ☐ Non Aboriginal ☐ Unknown ☐ Culture: _____

Preferred Language: English ☐ French ☐ Other _____

Language Delivery: English ☐ French ☐ Other _____

Highest Level of Education: _____

Health Card #_____ Expiry Date: _____ SIN: _____/_____/_____

Address:_____

CONTACT INFORMATION FOR PERSON BEING REFERRED:

Home Phone _____ ☐ permission to contact ☐ permission to leave a message
Work Phone _____ ☐ permission to contact ☐ permission to leave a message
Alternate Phone _____ ☐ permission to contact ☐ permission to leave a message
Email Address _____ ☐ permission to contact

REFERRAL SOURCE INFORMATION:

Name of Person Making Referral: _____

Connection to Person Being Referred: _____ Can we contact your referral source? ☐ Y ☐ N

Address of Referral Source (if different from above):

_____

Work Phone: _____ Email Address: _____

PSYCHIATRIC INFORMATION

Psychiatric diagnosis: Primary: _____Secondary:_____

Age of onset for mental illness: _____ Age of first hospitalization: _____

Are you living with an addiction? ☐ Yes ☐ No

If yes, please explain_____

_____

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Services **Currently** in Place: **(Please list specific services beside agency name)**

☐ ACTT 1 _____
☐ ACTT 2_____
☐ Addiction and After-Care Services (Please Specify) _____
☐ CMHA_____
☐ Centre Alliance Centre _____
☐ East Nipissing Mental Health Services _____
☐ Nipissing Mental Health Housing & Support Services _____
☐ People for Equal Partnership in Mental Health (PEP) _____
☐ Mental Health Clinic _____
☐ Community Care Access Centre _____
☐ Probation and Parole _____
☐ Other: (Please Specify) _____

REASON(S) FOR REFERRAL:

☐ Under 18 years of age and requires Trustee to manage finances (if this box is ticked, please provide name and contact number of primary support person: _____

☐ Assistance with Taxes ☐ Learning to budget ☐ Financial difficulties due to addictions
☐ Frequently using payday loans ☐ Behind on rent or utilities ☐ No money left at end of month

Please give any other reasons or details for this referral:

_____

_____

_____

★ ***You will be contacted to set up a first meeting to talk about your referral. Given the ongoing demand for our services, if you do not attend or call to cancel your appointment, your referral will be closed and you will be asked to submit a new referral if you require trusteeship services in the future.***

Date: _____

Name of Person signing this referral (Must be person being referred or Substitute Decision-Maker):

(Printed):_____Signature: _____

If you have made your mark above rather than signing, or if a Substitute Decision-maker has completed this Form, please have the mark/signature witnessed:

Date: _____ Witness' Name (printed): _____Witness' Signature: _____

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