Addiction Services
of Thames Valley | Services de toxicomanie de Thames Valley

French Mental Health and Addictions System Navigation Program
REFERRAL FORM

The following referral form is intended for an agency / organization or self referred individuals to the French Mental Health and Addictions System Navigation Program. Once completed, **please fax to (519) 673-1022,** or mail it at **260-200 Queens 'Ave, London, ON. N6J 1J3.** If you have any questions please call 519-673 3242 # 271

Internal ADSTV Referral (Open File)? ☐ Yes ☐ No *if* Yes, *please only complete areas with* *

We are here to help. How can we help you?

____

____

____

____

*** NAME:** ______________________________ ***D.O.B.** (d/m/y): ___________________________

LAST NAME at BIRTH: ________________

Client Canadian Born ☐ Yes ☐ No

Date of Arriving in Canada______________

GENDER: ☐ Male ☐ Female ☐ Other

Email address:___________________________

Okay to email? ☐ Yes ☐ No

DOES THE CLIENT HAVE
A FIXED ADDRESS? ☐ Yes ☐ No

STREET: _____________________________

APT/UNIT: _________________

CITY: __________________________________

POSTAL CODE: _____________________

HOME PHONE: (   ) ______________________
Okay to call? ☐ Yes ☐ No
Leave message? ☐ Yes ☐ No

OTHER PHONE: (   ) ______________________
Okay to call? ☐ Yes ☐ No
Leave message? ☐ Yes ☐ No

Person Responsible for the Client's Care /Next of Kin Guardian/Substitute Decision Maker:

Parent's /Guardian Names (if under 12): _________________

Address (if different from client):
____

Phone Number:_____________________________________

Email address:______________________________________

Okay to email? ☐ Yes ☐ No

*** PRESENTING PROBLEM/CONCERN (Check all that apply):**

☐ Mental Health Concerns ☐ Gambling Problems

☐ Addiction concerns ☐ Gaming Problems

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*** For Crisis Support:**

Presenting concern: ____

*** Medical Conditions/ History:**

____

(Currently have a GP/Family Doctor? ☐ Yes ☐ No)

*** Psychiatric Diagnosis:**

____

(Currently have a Psychiatrist? ☐ Yes ☐ No)

REFERRING AGENCY ONLY:

____

*** CONTACT**: ____________________________ **PHONE**: (   ) ________________ **EXT**: ________

FAX: (   )_____________________ **EMAIL**: ____

OTN EQUIPMENT AVAILABLE AT REFERRING SITE? ☐ Yes ☐ No

(IF Yes, Site#____________________ System #___________

I WOULD LIKE TO RECEIVE FEEDBACK REGARDING CLIENT'S INVOLVEMENT WITH ADSTV
(To receive feedback, the client must sign the *Consent for Release of Information* and/ or *Consent to the Collection, Use and Disclosure of Personal Health Information*) ☐ Yes ☐ No

CONTACT *Please choose one of the following:*

☐ Please contact me (referring agency) **BEFORE** contacting client.

☐ Upon receiving referral, please contact client directly.

SIGNATURE: ____ **DATE**: _________________________

FOR OFFICE USE ONLY

DATE RECEIVED:	CONTACTED? ☐ Yes ☐ No	INITIALS:
INTAKE COMPLETED? ☐ Yes ☐ No	INTAKE DATE:	INITIALS:
ELIGIBLE? ☐ Yes ☐ No	APPOINTMENT BOOKED? ☐ Yes ☐ No	INITIALS: