



An Ethnoracial
Mental Health Centre

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PROGRAM REFERRAL FORM

Surname: _____ First Name: _____

Gender _____ Age: _____ D.O.B: _____ Tel#: _____

Address: _____ Postal Code: _____

Ethnic Identity: _____ Place of Birth: _____ Year of entry to Canada: _____

Marital Status: _____ Canadian status: _____ Educational Status: _____

Contact Person: _____ Relation to client: _____ Tel.: _____

Health Card#: _____ Age of onset of illness: _____ Hospital: _____

Date of last hospitalization: _____ Number of hospitalizations this year _____

Psychiatrist: _____ Tel#. _____ Fax#. _____

Family doctor: _____ Tel#. _____ Fax#. _____

Alternative Therapist ;(Naturopath, Acupuncturist, etc) _____

Psychiatric Diagnosis: _____

Medications: _____

Reason for referral: Case Management/ Program/Family Counselling

What are the issues for which the service is needed? Please mark if they are applicable?

- | | |
|--|---|
| <input type="checkbox"/> Threat to others/attempted suicide | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Specific symptoms of serious Mental Illness | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Physical/Sexual Abuse | <input type="checkbox"/> Problems with relationships |
| <input type="checkbox"/> Educational | <input type="checkbox"/> Problems with substance abuse/addictions |
| <input type="checkbox"/> Occupational/Employment/Vocational | <input type="checkbox"/> Activities of daily living |
| <input type="checkbox"/> Housing | |

Other issues if any: _____

Referred by: _____ Tel#: _____

Agency/Relationship: _____

Current Program/Service: _____

Other Service Providers: _____

Date of Referral: _____ Date Assessed: _____ Date Admitted: _____

Across Boundaries is committed to protecting personal information,
by following responsible information handling practices in keeping with privacy laws.