"Rebuilding a life...
Renewing a dream"

Crisis Service G.P. Intake Referral
Direct Inquiries to Midland Office 705-526-1305 Ext. 236 or
Complete all sections and fax to: Midland Office 705-526-9248

Name_________________________________ Phone (H)___________________(B)____________________

Address_____________________________________ City/Town_____________________________________

Postal Code: _____________________ Gender: Man or Woman or I Identify as_______________________

D.O.B.(DMY)_____________ Marital Status__________ HC#____

Family Doctor_______________________________ Psychiatric Diagnosis _____________________________
(if known)

Formal/Informal Supports (please include past and present supports and any mental health providers involved with the individual):

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Current Medications:____

Medical/Health Issues:____

Current Presentation (circle appropriate response)

Suicide Risk:	Yes	No	Details: ___________________________
Violence Risk:	Yes	No	___________________________
Substance Abuse:	Yes	No	___________________________
Self-Harm:	Yes	No	___________________________

Please provide some background to your referral and any specific interventions you feel would be appropriate. Use back of page if needed:

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Referring Physician _________________________ Phone ___________________ Fax ___________________

Signature ____Date ____________________________

Revised Mar.2017