



Crisis Clinic Referral
Direct Inquiries to Midland Office 705-526-1305 Ext. 1247 or
Complete all sections and fax to: Midland Office 705-526-9248

Name: _____ Phone (H): _____ (BorC): _____

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):

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:

Referring Agency: _____ Phone: _____ Fax: _____

Signature: _____ Date: _____

If Client Consents for Follow-up by Wendat Community Programs Crisis Services please obtain client signature.

Signature: _____ Date: _____