Canadian Mental Health Association Huron Perth
Mental health for all

Association canadienne pour la santé mentale Huron Perth
La santé mentale pour tous

Date Received _____

Application for Service

CLIENT INFORMATION

Name *(please print)*: _____ D.O.B.: (M:D:Y) _____

Gender: _____ Marital Status: _____ Health Card Number_____

Address: _____ City: _____

Postal Code: _____ Phone: _____ Email:_____

How would you prefer to be contacted? ☐Phone ☐Email ☐Text

Okay to leave message? ☐ Yes ☐ No

What is your income source? _____

Are you currently in crisis? ☐ Yes ☐ No Do you have a current crisis plan? ☐ Yes ☐ No

Brief description of current crisis: _____

_____

Referred by (if other than self): _____

Name of emergency contact person: _____

Relationship:_____Phone: _____

Address: _____

MEDICAL

What is your mental health diagnosis? _____

What physical difficulties do you have? _____

Are you currently in hospital? ☐ Yes ☐ No

Date of admission: _____ Expected discharge date:_____

Date of most recent hospitalization: _____ Length of stay: _____ Hospital name: _____

Number of hospitalizations in the last two years: _____

Psychiatrist: _____ Phone: _____

Address: _____

Family Physician: _____ Phone: _____

Address: _____

List other agencies you are involved with: _____

_____

Have you been involved CMHA in past? ☐ Yes ☐ No If Yes, when did you receive services? _____

Please list all your medications: _____

_____

_____

_____

LEGAL

Do you have any current legal issues? *(select one)*

☐ Criminal ☐ Family ☐ I don't want to answer

If you have been charged criminally, what have you been charged with?: _____

_____

When is your next court date?: _____

In what city/town were you charged in?: _____

Do you have a lawyer?: ☐ Yes ☐ No What is the name of your lawyer?: _____

Are you currently on Probation/Parole?: ☐ Yes ☐ No Name of your Probation Officer: _____

Do you live with an abusive partner, roommate or family member? ☐ Yes ☐ No ☐ Unknown

If *yes*, please provide details: _____

Do you use alcohol or drugs (non-prescription or prescription)? ☐ Yes ☐ No ☐ Unknown

If *yes*, please describe use: _____

Have you had treatment for drugs/alcohol? ☐ Yes ☐ No ☐ Unknown

If *yes*, please provide details: _____

Do you self harm? ☐ Yes ☐ No ☐ Unknown

If *yes*, please provide details: _____

Have you attempted suicide? ☐ Yes ☐ No ☐ Unknown

If *yes*, please provide details: _____

Have you physically abused or been aggressive to others? ☐ Yes ☐ No ☐ Unknown

If *yes*, please provide details: _____

Have you damaged property? ☐ Yes ☐ No ☐ Unknown

If *yes*, please provide details: _____

Are there any further details you would like us to know? If *yes*, please provide details: _____

_____

What are you looking to achieve with the support of CMHA?

_____

_____

_____

What can CMHA Help you with?

_____

_____

Reasons for referral:

- ☐ Activites of Daily Living
- ☐ Attempted Suicide
- ☐ Educational
- ☐ Financial
- ☐ Housing
- ☐ Legal
- ☐ Occupational/Employment/Volunteer
- ☐ Physical Abuse
- ☐ Problems with Relationships
- ☐ Problems with Substance Abuse
- ☐ Sexual Abuse
- ☐ Specific Symptom of Mental Illness
- ☐ Theat to Others
- ☐ Other: _____

Did someone help you to complete this form? ☐ Yes ☐ No

If *yes*, who is this person? _____

(Name & relationship to client)

Applicants Signature: _____ Date: _____

If this application was completed by another Health Service Provider (HSP):

Has a Full OCAN assessment been completed for the individual being referred? ☐ Yes ☐ No ☐ Unknown

If *yes*, when was it completed and by whom? _____

(Date) *(Name of HSP)*