

Referral Form

Paris Satellite Office
The Willett Hospital
238 Grand River St N
Paris, ON
N3L 2N7
519-752-2998 ext. 128

Please Fax all Paris referrals to 519-442-9287

FIRST NAME: patFirstName LAST NAME: patSurname

Street Address patStreetAddress

City patCityAddress Postal Code patPostalCode

Date of Birth (mm/dd/yy) ...hdate.default (Eligibility Criteria - client must be 16 years or older)

Telephone patHomePhone.default (alternate contact) ...obilePhone.default ☐ No Phone

Health Card Number patHN Version Code ...ode

Family Doctor: patFam.fullName

Psychiatrist: _____

Client is aware of and consenting to referral: Yes ☐ No ☐

Mental Health Diagnosis: _____

Confirmed by Physician: Yes ☐ No ☐

Describe what kind of help or support is needed from CMHA:

Which services is the client currently connected to?

Any service delivery preferences or issues (i.e.: accessibility, times available, language, location, etc.)? _____

Referring Source:

currMdName
Name and agency (if applicable)

currMdPhone.default
Contact number

Signature

currentDate.short
Date