Working Together . . .
CCDP
community concurrent disorders program
. . . Towards Recovery

Please fax the completed referral to One-Link: 905-338-2878

Questions: **1-877-693-4270**

Referral Date: DD/MM/YYYY

☐ Consent to contact

Service Required:

☐ Crisis Support ☐ Case Management

☐ Community Withdrawal Management Service

Referral Source:	Contact Name:	Contact Number:

Client surname:		Given name(s):	
Health Card number (if available):	Birthdate: DD/MM/YYYY	Age:	Gender:
Address:	City:		Postal Code:
Phone:	Leave voice mail? ☐ Yes ☐ No	Identify service? ☐ Yes ☐ No	
Alternate method(s) of contact:			
Best time of day to contact: ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend ☐ Anytime			
Emergency contact:	Relationship:	Phone:	
Preferred Language:	Highest level of education completed:		
Location at time of referral: ☐ Hospital ☐ Shelter ☐ Residential Withdrawal Management Centre ☐ Community Anticipated Discharge Date, if applicable: DD/MM/YYYY			
Number of hospital visits in the past 6 months (Emergency Department and inpatient): ☐ 0-1 ☐ 2-5 ☐ 5+			
Mental health concerns? ☐ Yes ☐ No Age of onset:	Diagnosis (if any):		
Currently suicidal? ☐ Yes ☐ No	Previous suicide attempts? ☐ Yes ☐ No	History of aggression? ☐ Yes ☐ No Details:	
Medical Concerns (more space on back if needed):		Medications (more space on back if needed):	
☐ Requires psychiatric assessment ☐ Medication review/start medication ☐ Other:			
Current substance use status ☐ Currently in withdrawal ☐ Desire to cut back ☐ Desire to abstain from at least one mind or mood altering substance ☐ Does not wish to change current use	Substance use concerns:		

Canadian Mental Health Association Halton Region Branch *Mental health for all*
ADAPT HALTON ALCOHOL, DRUG and GAMBLING ASSESSMENT PREVENTION & TREATMENT SERVICES
PAARC Peel Addiction Assessment and Referral Centre
Trillium Health Partners
Halton Healthcare GEORGETOWN · MILTON · OAKVILLE
one-Link Connecting you to addictions and mental health services

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Client identified goals (check all that apply):		Please explain:
☐ Mental health	☐ System navigation	
☐ Addiction/substance use	☐ Financial	
☐ Housing	☐ Life skills	
☐ Counselling (marriage, grief, trauma)	☐ Other:	
☐ Legal	☐ Other:	

Client Supports – Check all that apply	Current Support	Referral(s) Completed	Details (Name, phone number)
CCDP: Crisis Support, Case Management, or Community Withdrawal Management Service	☐	☐	
Family Physician	☐	☐	
Psychiatrist	☐	☐	
Addiction	☐	☐	
Mental health	☐	☐	
Therapist/Counsellor	☐	☐	
Supportive Housing	☐	☐	
Other:	☐	☐	
Other:	☐	☐	

Additional Information (other risk factors, additional medical concerns/medications, etc.):

For internal use only
Referral sent to:

Date: