CRISIS OUTREACH REFERRAL ONLY

Fax this completed form to 905-315-9125
~Please call 289 291 5426 to ensure fax is received~

CRISIS OUTREACH – PROGRAM CRITERIA

Client must have ALL of the following:
- Client is aware of this referral and is agreeable to service
- Client is experiencing challenges with mental health and/ or substance use
- Client is deemed safe to be seen in the community by a single staff

Choose at least one - check all that apply
- ☐ Has multiple recent hospitalizations/ ED visits
- ☐ Requires immediate short-term support in stabilization of mental health and/ or substance use
- ☐ Is sober but is at a high risk of imminent relapse
- ☐ Is chronically suicidal and has had a change in baseline risk behavior

Please note: this is NOT an emergency service – referrals should expect contact within 48 hours

Referral Source:	Contact Name:	Contact Number:
Client is aware of this referral and is agreeable to service:	☐ Yes	☐ No

Client surname:		Given name(s):	
Health Card number:	Birthdate: DD/MM/YYYY	Age:	Identified Gender:
Address:		City:	Postal Code:
Phone:	Leave voice mail? ☐ Yes ☐ No	Can identify service on v/m? ☐ Yes ☐ No	

Location at time of referral: ☐ Hospital ☐ Shelter ☐ Residential Withdrawal Management Centre ☐ Community
Anticipated Discharge Date, if applicable: DD/MM/YYYY

Other supports involved:

Mental health / Addictions concerns:
Details/ Diagnosis:

Currently suicidal? ☐ Yes ☐ No Details:	Previous suicide attempts? ☐ Yes ☐ No	History of aggression? ☐ Yes ☐ No Details:

Reason for Referral:

Hospital referrals: please attach patient consultation notes