HOME AND COMMUNITY CARE SUPPORT SERVICES
Central West

MENTAL HEALTH & ADDICTION (MHAN) NURSE REFERRAL

Student's Name _____ Gender: ☐ Male ☐ Female

Home Address _____ City _____ Postal Code _____

Phone _____ DOB _____
DD / MM / YY

HCN _____ VC____

Family Physician _____ Child/Adolescent Psychiatrist _____

Parent/Guardian Contact Information

☐ Mother ☐ Father ☐ Guardian

Name _____
Home # _____
Cell # _____
Bus # _____
Address _____
City _____ Postal Code _____

☐ Mother ☐ Father ☐ Guardian

Name _____
Home # _____
Cell # _____
Bus # _____
Address _____
City _____ Postal Code _____

Languages Spoken in Home ☐ English ☐ French ☐ Other Specify _____

Interpreter Required ☐ No ☐ Yes Specify _____

Consent Information

☐ I give permission to the MHAN to notify my school _____ that I am participating in the MHAN program.

No other information will be shared by the MHAN program with my school without my informed consent. It is understood that my participation in the MHAN program will NOT be filed in my Ontario Student Record (OSR).

Verbal Consent for Referral Obtained from the Student ☐ No ☐ Yes Date _____
DD / MM / YY

Verbal Consent for Referral Obtained from Parent/Guardian ☐ No ☐ Yes Date _____
DD / MM / YY

School Information

School Board _____

School Name _____ Grade _____

School Address _____

City _____ Tel # _____ Fax # _____

Health Information D/C Summary Attached ☐ No ☐ Yes

☐ Diagnosis _____

☐ Allergies _____

☐ Other Agencies Involved with Student _____

Risk Factors

☐ Suicidal Ideation / Attempt / Risk to Self
☐ Risk to Others
☐ Parental Burden / Stress
☐ Medical Concerns Specify _____
☐ Recent Loss Specify _____
☐ Behavioural Concerns Specify _____

Potential Safety Concerns to Nurse

☐ Infectious Condition
☐ Smokers in the Home
☐ Firearms
☐ Pets
☐ Other Specify _____

Ontario

Alcohol / Substance Abuse

☐ Daily Specify _____

☐ Multiple x/Day Specify _____

☐ Irregular Use Specify _____

Please Include Additional Information and Summarize Clearly Reason for Referral:

To reduce duplication, information already available in the system is highly valued and should be attached to the referral:

Medical / Social Work / Psychiatric History ☐ Attached

Medications *(please attach list)* ☐ Attached

Recent Laboratory Results *(within 3 months)* ☐ Attached

Referral From:

☐ Family Physician ☐ Pediatrician / Psychiatrist ☐ Nurse/ Nurse Practitioner ☐ Social Worker

☐ Child & Youth Worker ☐ School Psychology Staff ☐ Other

Name _____

Phone/Backline # _____

Fax # _____

Signature _____ Date _____

******* Complete Information Facilitates the Referral Process *******

Please fax this referral form along with discharge notes to
Home and Community Care Support Services Central West intake fax # 905-796-4673

A Home and Community Care Support Services Central West Mental Health Nurse will contact the student or parent/guardian to confirm consent and book an appointment.