Mental Health and Addictions Nursing Program Referral Form

\*Fax complete forms to 905-444-2551/ 1-855-787-4838

**PATIENT NAME:**  Date of Birth (D/M/Y):

**□**

**□**

**□**

**Durham District School Board** Phone:905- 666- 6359 Fax: 905- 666 -6089

**Durham Catholic District School Board** Phone: 905-576-6150/1-877-482-0722 Ext. 22103 Fax: 905-432-6886

**Kawartha Pine Ridge District School Board** Phone: 1-877 -741- 4577 Ext. 2177 Fax: 705- 760-8685

Fax: 705-748-5187

**□ Peterborough Victoria Northumberland Clarington Catholic DSB** Phone: 705- 748-4861/1-800-461-8009 Ext. 1213

DATE (D/M/Y)

SCHOOL

Address:

City:

Postal Code

Phone: ` Other Phone #:

Gender: M F Other

Health Card Number: (Required) Language:

**Contact Person/SDM/POA (REQUIRED) Name**:

Signature: Relationship: Phone:

Patient Parent/Guardian has provided verbal consent for referral. Reason for Referral:

(Required) Please check all that apply:

Capacity Building with School Safety Planning Illness Symptom Management Family Support Medication Management Addiction Support Linkage to Community Support/ Counselling

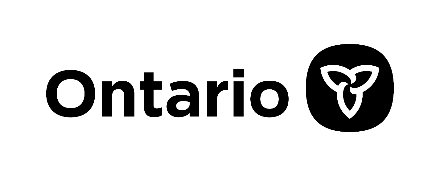
Healthy Coping Skills Development

Primary Care Provider Phone:

Referred By: School Board Primary Care Provider Community Agency Hospital

Organization Name:

Referral Contact Name:

Referral Contact Signature:

CE-MHAN-05 (08/22)

**Phone:**