**COMMUNITY MENTAL HEALTH**

CHILD & ADOLESCENT and ADULT

REFERRAL FORM



**Central Intake provides a welcoming point of contact for individuals and their families/natural supports seeking mental health services in the community. Acting as service navigators, Central Intake will contact individuals referred to discuss the presenting situation/goals for service and will help determine which programs offered by Community Mental Health would be the best fit for the individual or provide direction towards other programs which may be able to better support individuals as they meet their goals.**

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| --- | --- | --- | --- | --- |
| **Date**: | | **Referral Source**: | | |
| **Phone Number**: | | **Fax Number**: | | |
| **Name:** | | | | | |
| **PHIN #:** | **MHSC #:** | | | **Gender:** | |
| **D.O.B.:**       /      / | | | **Physician/NP:** | | |

**Month/Day/Year**

|  |  |  |
| --- | --- | --- |
| **Address:** | **Town:** | **Postal Code:** |

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| **Preferred Contact Phone Number:** |
| **Name of Legal Guardian (Parent or CFS) or Emergency Contact:** |
| **Phone # of Legal Guardian (if different from above):** |
| **Involved with Community Living Disability Services:**  **Yes**  **No** |
| **Presenting Concerns:** |