**Counselling Centre of East Algoma**
9 Oakland Blvd. Suite 2
Elliot Lake, ON, P5A 2T1
Phone: 705-848-2585

# Agency Referral Form

## Fill out and fax completed form to: Fax: 705-848-9687

## REFERRAL INFORMATION

**Date of Referral** (dd/mm/yyyy)

**Referring Agency:**

**Referring name:**

**Contact Information:**

## CLIENT DEMOGRAPHICS

**Name** (First and Last))

**DOB** (dd/mm/yy)

**Health Card**

**Address:**

**Contact information**

**Gender Identity:**

☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐non-Binary ☐Two-Spirit

**Family Physician Name**

**Psychiatrist name**

**Current medication list:**

**Mental health diagnosis:**

**Relevant medical information:**

**COMMUNITY SERVICE PROVIDERS:**
Please indicate if the client is using any other of the following:

| | **Agency Name** | **Collateral Contact Name** |
|---|---|---|
| ☐ Family Services | _____ | _____ |
| ☐ Addiction Services | _____ | _____ |
| ☐ Shelters | _____ | _____ |
| ☐ Mental Health Services | _____ | _____ |
| ☐ Medical Health Services | _____ | _____ |
| ☐ Legal Services | _____ | _____ |
| ☐ Victim Services | _____ | _____ |
| ☐ Senior Mental Health Services | _____ | _____ |
| ☐ Social Services | _____ | _____ |
| ☐ Other | _____ | _____ |

## SERVICES REQUESTED:

**Presenting Issues - Select all that apply.**

| | | |
|---|---|---|
| ☐ Addictions | ☐ Harm to self | ☐ Harm to others |
| ☐ Housing | ☐ Abuse | ☐ Activities of daily living |
| ☐ Symptoms of mental health | ☐ Education/Vocation/Employment | ☐ Financial |
| ☐ Inability to care for self | ☐ Chronic Illness/medical conditions | ☐ Other: _____ |

**Services Requested – Select all that apply.**

| | | |
|---|---|---|
| ☐ Addictions Case Management | ☐ Addictions Treatment | ☐ Harm Reduction |
| ☐ Family Violence | ☐ Domestic Violence (Male) | ☐ Sexual Assault (Male) |
| ☐ Mental Health Abuse | ☐ Mental Healthy Treatment | ☐ Community Support |
| ☐ Gender Based Violence | ☐ Sexual Assault (Female under 16) | ☐ Relationships |
| ☐ Intervention | ☐ Other: _____ | |

**Reason for this referral: Please provide as much detail as possible.**

**Is the individual aware of and in agreement with this referral:** ☐ Yes ☐ No

**Have you included other documentation to this referral?** ☐ Yes ☐ No