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

Medical Referral Form

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

REFERRAL INFORMATION

Is this referral from:

☐ St. Joseph's General Hospital ☐ North Shore Health Network
☐ Elliot Lake Family Health Team ☐ Other: _____

Date of Referral (dd/mm/yyyy)	
Referring name:	
Contact Information:	
Date of visit/admission (dd/mm/yyyy)	

Reason for presenting at Emergency Department:

Please indicate the level of urgency for client contact:

☐ Within 24 hours – Community Intervention
☐ Other programing

CLIENT DEMOGRAPHICS

Name (First and Last))

DOB (dd/mm/yy)

Health Card

Address:

Client 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:

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