


“Every Door is the Right Door”


Frontenac Community Mental Health Services
 ACT & Case Management Intake
 552 Princess Street
 Kingston, ON K7L 1C7

Contact:

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NOTE: 1) Signature acknowledges that this referral will be assessed by one of the *FLA Access Coordinators*
 check here to indicate that we can contact the most appropriate service for your client, and redirect the referral

2) PLEASE FORWARD ANY RELEVANT CONSULTATION REPORTS / DISCHARGE SUMMARIES.

Client Information	Referral Agent Information
Name: Address: Date of Birth (dd/mm/yy): __ / __ / __ Telephone (home): Telephone (work): Alternate contact person (name): Alternate contact person (phone #): Health Card #: Health Card Version code: May we contact the client directly? <input type="checkbox"/> Yes <input type="checkbox"/> No Can a detailed message be left? <input type="checkbox"/> Yes <input type="checkbox"/> No Any Communication barrier? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify:	Date of Referral: Agency / Source: Telephone: Fax: Family Physician / Psychiatrist: (if different from above) Telephone (direct):
Reason for the Referral:	
CURRENT SITUATION	PSYCHIATRIC HISTORY
Current working psychiatric diagnosis	Previous diagnoses <input type="checkbox"/> None
Current mental health / psychiatric contacts <input type="checkbox"/> None / community supports (please describe)	Previous out-patient mental health <input type="checkbox"/> None and/or addiction treatment (please describe)
Current medical conditions <input type="checkbox"/> None (please describe)	Previous in-patient psychiatric admissions <input type="checkbox"/> Yes <input type="checkbox"/> No (please describe)
Current medications (please describe) <input type="checkbox"/> None	
Signature: _____ Date: _____	
(of Referral Source)	