HOME AND COMMUNITY CARE SUPPORT SERVICES
South West

Referral – Mental Health and Addiction Nursing Program

Student information

Last Name: ..... First Name: .....

Pronoun: ..... HCN: ..... D.O.B.: ..... Grade: .....

Home Address: ..... City: ..... Postal: .....

Preferred Student Contact Number: .....

Physician and Family

☐ **Physician involved** Name: ..... Contact Number: .....

PRIMARY CONTACT:
☐ Mother ☐ Father ☐ Guardian **Ok to contact:** ☐ Yes ☐ No

Name: .....
Home: .....
Cell: .....
E-mail: .....

SECOND CONTACT:
☐ Mother ☐ Father ☐ Guardian **Ok to contact:** ☐ Yes ☐ No

Name: .....
Home: .....
Cell: .....
E-mail: .....

Custody arrangements/orders: (both signatures required in joint custody agreements)

Consent

Date Consent obtained from: ☐ Student: (D/M/Y) .....

Date Consent obtained from: ☐ Parent ☐ Guardian: (D/M/Y) .....

Reason for Referral: (Detailed referral information is required)

☐ Anxiety ☐ Self Harm ☐ Substance Use ☐ Disordered Eating
☐ Depression ☐ Suicidal thoughts ☐ Medication Change ☐ Other

Please explain:

What is the desired outcome of MHAN involvement: .....

Previous counselling / interventions prior to referral and the outcome :

List any current active community mental health counselling/supports:

_____
Teacher & School & School Board

_____ _____
School Contact (please print) Title

_____ _____
Signature Date: (D/M/Y)

Please FAX Completed Referral to: SWLHIN School Health Support Services Team VIP Fax Line: **Toll Free 1-844-800-4578**
SWLHIN School Health Support Services Team VIP Line: **Toll Free 1-877-900-5667**
A LHIN MHAN will contact the student or parent/guardian to determine/confirm consent for appropriate referrals.

Ontario