

Outpatient Mental Health and Addiction Services

519-751-5530

FAX Referrals: 519-751-5548

Email: mhreferrals@bchsys.org

Please complete fully including the route to reach you with questions.

We Accept Self Referrals

BCHS Outpatient Mental Health and Addiction Programs

We offer other services and specialty groups that are not listed. At intake, we direct clients to the most appropriate and available service.

- ☐ **Crisis Counselling** (age 18+) (Brief Therapy Program)
- ☐ **Early Intervention** (age 16-24)
- ☐ **Early Psychosis Intervention** (age 14-35, psychotic symptoms present for less than 1 year)

Acute Day Treatment and Medication Clinic are accessed by an alternate referral process. Please call (519) 751-5544 Ext: 2657 for more information about these two programs.

Client Last Name		Client First Name		Middle Name	
Address (Street #)		City/Province		Postal Code	
Phone Number(s)		Gender Identity		Preferred Pronoun	
Date of Birth (D/M/Y)		Age			
Email Address				OHIP # including Version Code	
Interested in/prefer Indigenous centred counselling?		Yes <input type="checkbox"/> No <input type="checkbox"/>		Client aware of and / or agrees with referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Interpreter required ?		Yes <input type="checkbox"/> No <input type="checkbox"/>		Can a confidential message be left on voicemail? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Family Physician: _____				Phone: _____	
Psychiatrist: _____				Phone: _____	

Referral Criteria: A Mental Health/Addiction Concern/Presenting Concerns: Please check the following area(s) of concern that apply:

- | | |
|---|---|
| <input type="checkbox"/> Depressive Disorder | <input type="checkbox"/> Grief and Loss (not as primary concern) |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Concurrent Disorders (Addiction + MH concerns) |
| <input type="checkbox"/> Personality Disorder | <input type="checkbox"/> Family Education / or Support Groups |
| <input type="checkbox"/> Bipolar and Related Disorders | <input type="checkbox"/> Peer Support Program |
| <input type="checkbox"/> Schizophrenia Spectrum/other Psychotic Disorders | |

Please share Clients goals for counselling (Required) :

Current Risk: (High/Moderate/Low) ☐ **Harm to Self** _____ ☐ **Harm to Others** _____
We respond promptly but not immediately to referrals. If risk level warrants, please access Emergency Services. More details / other concerns:

Other Information: (Including reason for referral, involvement with other services/counselling, eligibility for EAP, medications) (Attach relevant documents)

Internal Use: Appt. Date:

Time:

Counsellor:

Clients under age 16, please call Contact Brant: (519) 758-8228. Please contact a psychiatrist's office directly to discuss or make a referral to a psychiatrist. We do not offer forensic assessment or treatment, MVA assessment, or adult ADHD assessment. We are unable to provide assessments for legal, custody, disability, insurance or Workers Compensation issues, Please confirm that this is not a referral for such a consultation. Confirmed