



200 Terrace Hill Street  
 E-Wing, Main Floor  
 Brantford, Ontario  
 N3R 1G9  
**519-751-5530**

# Outpatient Mental Health and Addiction Services

Date: \_\_\_\_\_ Referring Agency: \_\_\_\_\_  
 Referring Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**FAX Referrals: 519-751-5548**  
**Email: [mhreferrals@bchsys.org](mailto: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, new onset symptoms or no prior treatment)  
 **Psychiatry Consultation** (age 18+, Family physician required)

**Acute Day Treatment, Child and Adolescent Clinic and Medication Clinic are accessed by an alternate referral process. Please call (519) 751-5544 ext. 2657 for more information about these three programs.**

Client Last Name \_\_\_\_\_ Client First Name \_\_\_\_\_ Client Middle Name \_\_\_\_\_  
 Address (Street #) \_\_\_\_\_ City/Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone Number(s) \_\_\_\_\_  
 Gender Identity (Preferred Pronoun) \_\_\_\_\_ Date of Birth (DD/MM/YYYY) \_\_\_\_\_ Age \_\_\_\_\_  
 Email Address \_\_\_\_\_ OHIP # including Version Code \_\_\_\_\_  
 Allergies \_\_\_\_\_ Other Medical Issues (asthma, diabetes. etc.) \_\_\_\_\_  
 Next of Kin Name or Emergency Contact \_\_\_\_\_ Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Interested in/ prefer Indigenous centered Counselling? Yes  No  Interpreter required? Yes  No   
 Can a confidential message be left on voicemail? Yes  No  Client aware of/agrees with referral? Yes  No   
 Is the client already seeing a counsellor? Yes  No   
 (If yes, please do not refer until counselling is closed)

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

**Reason for Referral:** Please check the following area(s) of concern that apply:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Neurodevelopmental Disorder (ADHD, autism, etc.) | <input type="checkbox"/> Compulsive behaviours     | <input type="checkbox"/> Sleep problems               |
| <input type="checkbox"/> Delusions/ Paranoia                              | <input type="checkbox"/> Obsessive thoughts        | <input type="checkbox"/> Gender dysphoria             |
| <input type="checkbox"/> Hallucinations                                   | <input type="checkbox"/> Grief reaction            | <input type="checkbox"/> Impulse control              |
| <input type="checkbox"/> Psychosis  | <input type="checkbox"/> Problematic substance use | <input type="checkbox"/> Personality related          |
| <input type="checkbox"/> Elevated mood                                    | <input type="checkbox"/> Stress                    | <input type="checkbox"/> Mood instability             |
| <input type="checkbox"/> Depressed mood                                   | <input type="checkbox"/> Trauma                    | <input type="checkbox"/> Self-injury/self-harm        |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Dissociation              | <input type="checkbox"/> Suicidality                  |
|   | <input type="checkbox"/> Somatic symptoms          | <input type="checkbox"/> Other mental health symptoms |

**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:**

*If this section is left blank, we are assuming that the risk is low.*

**Primary Concern and Other Information:**

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

- Please contact office directly to discuss or make a referral to community psychiatrists including Dr. Book, Dr. Briskin, Dr. Sharma or Dr. Prayaga.
- We do not offer forensic assessments or treatment or MVA assessment.
- We are unable to provide assessments for legal, custody, disability, insurance or Workers Compensation issues.

**Internal Use**

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Counsellor: \_\_\_\_\_