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
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** **(Internal Only)** (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 (Recommended) _____ 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 ☐

Can a confidential message be left on voicemail? Yes ☐ No ☐

Is the client already seeing a counsellor? Yes ☐ No ☐
(If yes, please do not refer until counselling is closed)

Interpreter required? Yes ☐ No ☐

Client aware of/agrees with referral? Yes ☐ No ☐

Primary Care Provider: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Pharmacy: _____ Phone: _____

Client Initials: _____

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

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

Please share clients goals for Program (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, Medication, and Other Relevant 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: _____