Canadian Mental Health Association
Thames Valley
Addiction and Mental Health Services

Association canadienne pour la santé mentale
Thames Valley
Services de santé mentale et de traitement des dépendances

Substance Use Outreach Program
REFERRAL FORM

The Substance Use (SU) Outreach Program provides treatment for addictions and mental health concerns for those residing within London community. This occurs in a mutually agreed upon location, that is easily accessible for the client. SU Outreach counsellors will, where appropriate, provide brief solution focused therapy with a goal of minimizing a client's barrier(s) to attending services while actively working on substance use concerns.
Referrals received based on preference to attend at individuals' home or to meet in the community, with no identified limitations accessing supports, will be directed to the *Substance Use* program, where sessions can occur in person and/or virtually.

Client's Name:_________________________________ **Database # (if internal):** __________________

D.O.B. (dd/mm/yyyy): ___________________________ **Gender:**_____________________

Telephone: (   ) _______________________________ Okay to leave message? ☐ Yes ☐ No

Email: ____ Consent on file? ☐ Yes ☐ No

Address: ______________________________________ **City:** ☐ London **Postal Code:** __________

Barrier(s) to accessing services? ☐ Yes ☐ No. **If yes, please explain**

____

____

Open to ongoing services in person? ☐ Yes ☐ No (if no, refer to intake)

____

____

Substance(s), and/ or Gambling and/or Behavioural Addictions of concern. Please outline any other relevant information:

____

____

Please list any other community support connected to the care team:

____

____

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Name: ____________________________
ID #: ________________________

Referring Agency: ☐ **Myself** ☐ **Family** ☐ **3rd party** ☐ **Other**

Contact Name: ______________________________ Organization: ________________________

Phone: (   )________________ ext _____ Fax: (   )_____________________________

Email:__________________________________

Additional Comments:____

____

____

Signature:__________________________________ **Date**:__________________________________

FAX COMPLETED FORM TO: 519-673-1022

QUESTIONS OR INFORMATION?

EMAIL: SUOutreachProgram@cmhatv.ca or Call Reception: 519-673-3242 ext. 222

Pursuant to the Personal Health Information Protection Act (PHIPA), 2004

ADSTV – Consent to the Collection, Use and Disclosure of PHI

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Name: ____________________
ID #: ____________________

CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION ATTACHED

All CMHA TVAMHS employees are mandated under law to protect the personal health information and clinical records of every client. Signing this form will allow consent for the sharing/disclosure of your personal health information between CMHA TVMHAS and the agency/ person noted below.

I ______________________________, born on ______________________________
(Print name) (dd/mm/yyyy)

authorize CMHA Thames Valley Addiction and Mental Health Services (CMHA TVMHAS) to:

☐ (initial) disclose and/or

☐ (initial) receive

my personal health information with

____, as follows:

Print the name of the agency/ person with whom you permit CMHA TVMHAS to share your personal health information

Relevant information from my clinical file ______
Initial

Or specifically:

______________________________ ______
Initial

______________________________ ______
Initial

______________________________ ______
Initial

______________________________ ______
Initial

This consent shall be in effect until ________________.
dd/mm/yyyy

This agreement may be cancelled by you at any time.

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Witness Name (Please Print) Witness Signature