ST. LEONARD'S COMMUNITY SERVICES
ADDICTIONS AND MENTAL HEALTH
INTAKE REFERRAL FORM

Client Name: ____

Date of Referral: ____________________ Date of Birth: ____________________________
(dd/mm/yyyy) (dd/mm/yyyy)

Address: ____

Telephone: ____

Can a confidential message be left on voice mail? Yes No
Can a confidential message be left with others? Yes No

REFERRAL SOURCE:

Name/Title: ___________________________Agency:___________________________

Telephone/Extension: _________________________ Fax: _________________________

Is the individual aware that a referral has been made? Yes No
Is the individual currently in hospital? Yes No

Hospital Floor/Room Number: ____

Estimated Discharge Date: ____

Presenting Issues: Drug Use ◯ Gambling ◯
Alcohol Use ◯ Concurrent Disorder ◯

Comments:

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***Please fax Referral form to 519-754-0264 Attn: Nicole Brown, Addictions and Mental Health Administrative Support.**