REFERRAL AND INTAKE FORM

Referral Source Name:	**Date:**
DEMOGRAPHIC INFORMATION	
Name:	
PHIN (nine digit):	
__ __ __ __ __ __ __ __ __	
MHSC (six digit):	
__ __ __ __ __ __	
Date of Birth:	
Treaty Number:	
Address	
Street: **City/Town:** **Postal Code:**	
Phone Number	
( ) _____ - _____	May we leave a voicemail regarding appointments (please circle)? **Yes or No** Signature: Date:
Email Address	
_____	May we send correspondence about appointments via email? Yes or No Signature: Date
Relationship Status	
	Please Circle one: Married Divorced Common Law Single Other
Community Mental Health Worker	
Name:	Phone:

Emergency Contact Information	
Name: Phone Number:	Relationship to Emergency Contact: _____
Family Physician:	
Name: Phone:	
Allergies (please list)	
• • • •	
Medications	
Name Dose 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	
Previous Diagnosis	