|  |  |
| --- | --- |
| **Referral Source/Date:** |       |
| **Is client aware of referral?** |       | **Are we able to identify you as a referral source?** |       |
| **CLIENT INFORMATION:** |
| **Name:** | **Gender:** | **D.O.B:** |
|       |       |       |
| **Address:** | ***Telephone:*** |
|       | (   )    -     |
| **OHIP Number:** |
|      |
| **Emergency contact**: |
|       |
| **Mental Health Diagnosis (if known)**: |
|  |
| **Medications:**  |
|       |
| **Substance Abuse: (Frequency/Duration):** |
|       |
| **Psychiatrist and Family Doctor/Nurse Practitioner:** |
|       |
| **Reason for Referral:** |
|         |
| **Any safety concerns or hazards within the home: (ie: bed bugs, weapons, violence)** |
|       |

**Contact (519) 973-4409, Email:** **windsor.coast@hdgh.org****, or**

**Fax: (519) 973-1989**