CENTRAL WEST CONCURRENT DISORDERS
SPECIALIZED SUPPORT SERVICES REFERRAL FORM

Date: Health Card #:

First Name:		Last Name:
DOB: _____/_____/_____ mm / dd / yyyy	Phone #:	Address: Unit #:
City:	Province:	Postal Code:

Male ☐ Female ☐ Other: _____

Resident Type:

Owned/Rent ☐ Subsidized ☐ Shelter ☐ Homeless ☐ Unknown ☐ Other: _____

Living Arrangement:

Self ☐ Parents ☐ Children ☐ Spouse/Partner ☐ Non-Relatives ☐ Unknown ☐ Other: _____

Support Type:

Independent ☐ Assisted/Supported ☐ Supervised ☐ Unknown ☐ Other: _____

Mental health concern? Yes ☐ No ☐ If yes, what is your diagnosis? _____

Do you have substance use issues? Yes ☐ No ☐ If yes, describe? _____

Source of income:

ODSP ☐ OW ☐ Pension ☐ Family ☐ Employment ☐ Unknown ☐ Other: _____

Employment Type:

No Employment ☐ Independent/Competitive ☐ Unknown ☐ Other: _____

Education Level:

University ☐ College ☐ High School ☐ Elementary ☐ Other: _____

Legal Status:

No Problems ☐ On Probation ☐ On Parole ☐ On Bail ☐ Other: _____

Referral Source:

Name: _____ Position: _____

Organization: _____ Phone #: _____

Please send completed referral forms to:
Reconnect Mental Health Services
56 Aberfoyle Crescent. 4th Floor, Etobicoke, ON, M8X 2W4
Tel: 416 248 2050 Fax: 416 248 6557