Canadian Mental Health Association Durham
Helping people move forward

60 Bond Street West
Oshawa, ON, L1G 1A5
Tel: (905) 436-9945
Fax: (905) 436-9313

Palliative Primary Health Care and Outreach Services

Client Information:

_____ _____ _____
Client's First Name *Last Name* *Client's Preferred Name*

_____ _____
Gender *Language(s) Spoken*

Phone Number: _____ *(permission to leave message* ☐*)*

_____-_____-_____-_____ _____/_____/_____
Health Card Number *Date of Birth:* DD MM YYYY

_____ _____ _____
Address *City* *Postal Code*

_____
Allergies

Does this client have a Primary Care Provider? ☐ Yes ☐ No
(Primary Care Nurse Practitioner or Family Doctor)

Reasons for Referral: _____ **Housing Situation**: _____

_____ _____

Reason Client is Unable to Access Mainstream Health Care Services: _____

_____

Does this Client Require Palliative Primary Care? ☐ Yes ☐ No
Primary Palliative Diagnosis: *Date of Diagnosis if known (mm/yy):*

Mental Health Diagnosis:

Please fax this form to Community Connection Services at 905-436-1569

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Risk Assessment (*must be completed*):

☐ Hx Violence towards others ☐ Sexual aggression ☐ Hx Concealing weapons
☐ Hx Violence towards self ☐ Hx Suicide Attempt ☐ Hx Fire-setting
☐ Hx Violence towards property ☐ Pets ☐ Smoking in the home
☐ Roommate/ Family concerns ☐ Falls *(if yes, describe functional mobility/assistive devices)*:

_____

☐ Substance Use (type, amount, frequency)

_____

☐ Any other risks: _____

Legal Status: *(if no legal involvement, leave this section blank)*

☐ Criminal record ☐ NCR ☐ Current charges *(if yes, please describe)*:

_____

Referral Source Information:

☐ *I'm referring myself* ☐ *I'm referring a client **with their consent**:*

_____ _____
Referrer's Name (if not the client) *Phone Number*

_____ _____/_____/_____
Relationship to Patient *Date of Referral:* DD MM YYYY

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