Canadian Mental Health Association Durham

Phone: 905-436-8760 or Toll Free: 1-844-436-8760 Fax Number: 905-436-1569

Email: cmha@cmhadurham.org

Website: www.cmhadurham.ca

Referral to the Mental Health and Addictions Peer Support Program (MAPS)

Client Contact Information:

______________________ ______________________ ______________________

First Name **Last Name** **Preferred Name**

______________________ ________/________/________

Phone Number (Permission to leave messages ☐) **Date of Birth: DD MM YYYY**

(Permission to Text ☐)

Preferred method to be contacted:

- ☐ Email
- ☐ Phone
- ☐ Text

____

Email Address (Permission to email ☐)

______________________ ______________________ ______________________

Address **City** **Postal Code**

Is there a Mental Health Diagnosis: Yes No Comments: ____________________

Is there a Physical Health Diagnosis Yes No Comments: ____________________

Addiction Supports Required Yes No Comments: ____________________

Additional Comments:

Please contact us if you have any further questions or visit us online. The MAPS Peer support Specialist will contact the referring individual to assess the referral and begin to develop a care plan

for the individual.

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Referral Source Contact Information (Must be included):

Probation or Parole Contact: ____

Phone Number: __________________ Extension: ________________________ Fax: ________________

Reason for referral:

Is client aware of the referral and in agreement to attend this program?

- ☐ YES
- ☐ NO

Does client have access to internet and/or data?

- ☐ YES
- ☐ NO

Does the client have one of the following for virtual visits?

- ☐ Smart Phone
- ☐ Tablet
- ☐ Computer

Does client require additional support or training on how to connect for virtual appointments/ courses?

- ☐ YES
- ☐ NO

I consent for my PO to speak about the Mental Health and Addictions Peer Support Specialist

- ☐ YES
- ☐ NO

What needs do you think the client has?

Please complete this referral form and fax to 905-436-9561

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for the individual.