Canadian Mental Health Association Durham
Mental health for all
Association canadienne pour la santé mentale Durham
La santé mentale pour tous

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 AND REQUEST FOR COMMUNITY MENTAL HEALTH SERVICES

Please be advised that CMHA Durham has walk-in supports available Monday to Friday 9-6:30

Using this referral form, please select the program(s) that are most applicable. Please contact us if you have any further questions or visit us online.

☐ **Housing and Case Management Services**	Provides support to individuals with a mental health diagnoses living in the community. *Currently Housing Case Management only accepts referrals to their case management program.
☐ **Caregiver Case Management**	Support specific to the individual caregiver with emphasis on education and relief for caregiver stressors for a period of up to 3 months.
☐ **Brief Case Management Services**	For individuals seeking 1:1 support with a case manager, available for a period of up to 3 months.
☐ **Criminal Justice Case Management Services**	Case Management support that specializes in criminal justice matters, for a period of up to 3 months.
Referral forms available from our website www.cmhadurham.ca. for the following services;	
Assertive Community Treatment Team *Provide 1-2 years of psychiatric history faxed with ACT referral form please	A client-centered, recovery-oriented mental health service for individuals between the ages of 18 to 65 with serious and persistent mental illnesses.
Nurse Practitioner-Led Clinic (Primary Care)	Provides a full range primary care services to clients and their families who do not have a primary care provider.

Client Information

First Name: _____ Last Name: _____ DOB: _____

Address: _____

Telephone: _____ Cell Phone: _____

Permission to Leave messages ☐ Permission to Text ☐

Is there a Mental Health Diagnosis ☐ Yes ☐ No

Is there a Physical Health Diagnosis ☐ Yes ☐ No

Additional Comments: _____

Referral Source: _____

Telephone: _____ Fax: _____