Ontario Health atHome

REFERRAL FOR MENTAL HEALTH AND ADDICTIONS NURSING (MHAN)

Student's Last Name:	Student's First Name:	
Gender: ☐ Male ☐ Female	Date of Birth (DD/MM/YYYY):	
Health Card Number:	Contact Number:	
Home Address:		Apartment #:
City:	Province: ON	Postal Code:
☐ Mother ☐ Father ☐ Guardian Name: Home: Cell: Business:	☐ Mother ☐ Father ☐ Guardian Name: Home: Cell: Business:	
Other Emergency Contact (Name & Relationship):		Phone:
Languages Spoken in Home (Maternal Tongue): ☐ English ☐ French ☐ Other: Interpreter required? ☐ No ☐ Yes ☐ Specify:		
Date Verbal Consent for Referral obtained from the Student and/or Parent/Guardian (DD/MM/YYYY)**:** **Name and relationship of person providing consent:**		
School Board:	School Name:	Grade:
School Address:		
City:	Province: ON	Postal Code:
Telephone:		Fax:
Additional Information/Reason for Referral: (please ensure Student and/or Parent/Guardian consents to share health information with other agencies involved):		
☐ Mental health concerns (i.e.: depression, anxiety):		
☐ Diagnosis consultation:		
☐ Medication management:		
☐ System Navigation:		
☐ Early Identification / Intervention:		
☐ Follow-up with student from in-patient program (hospital)/youth justice system:		
☐ Addictions:		
☐ Other:		

Referral Source: _____ **Contact Number:** _____

Print Name/Sign: _____ **Position:** _____ **Date:** _____ DD/MM/YYYY

Send To: Fax #: **705-267-7795**

A Mental Health & Addictions Nurse will contact the student or parent/guardian to determine or confirm consent.