Community Care Durham
SUPPORTING PEOPLE, STRENGTHENING COMMUNITY

COPE MENTAL HEALTH REFERRAL FORM

FAX: 905-668-7190
EMAIL: cope@communitycaredurham.on.ca

Date:	Is Client Aware of the Referral: · Yes · No

CLIENT INFORMATION

Client Last Name: First: Middle Initial:	Pronouns: ❑ She/Her ❑ He/Him ❑ They/Them ❑ Unknown ❑ _____

Language(s) Spoken:	Birth date: (MM/DD/YYYY)	Age:

Street address:	Apartment/Unit Number:	City:

Postal Code:	Home Phone Number: ( )	Cell Phone Number: ( )

Email Address:	Family Doctor Name: Phone: ( )	Preferred Method of Contact: ❑ Home ❑ Cell ❑ E-mail

Referral Source:	Referral Source Phone Number: ( )

Other Active Supports:

❑ Family/Friends	❑ Case Management	❑ Ontario Shores	❑ Counsellor/Social Worker	❑ Psychiatrist

Other Supports:

Mental Health Diagnosis (select all that apply): ❑ NONE

❑ Anxiety Disorder ❑ Depressive Disorder ❑ Bipolar Disorder ❑ Personality Disorder ❑ Schizophrenia Spectrum ❑ Trauma Disorder ❑ Other

Current Legal Issues:

❑ None ❑ Civil ❑Criminal ❑ Unknown

SERVICE INFORMATION

SERVICE REQUESTED: **Group Support** ❑

Current symptoms/risk behaviours, accommodation need, medical conditions ,etc.:

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IN CASE OF EMERGENCY

Emergency Contact:	Relationship to Client:	Home Phone Number: ( )	Cell/Work Phone Number: ( )