INTAKE FORM

Please complete all fields. Please note that incomplete referrals will be sent back to referral source for all required information.

Date: M/D/Y Click here to enter a date.	**Name:** **Address:**	**D.O.B. M/D/Y** **Health Card Number:** _______________________	**Referred By:** ☐ **Self** ☐ **Other** ____________________	**Referral contact number:**
Telephone:	**Best Time To Call:** A.M.☐ P.M.☐	**Alternate Contact (email if preferred):**	**Can we Leave a Message?** Yes ☐ No ☐ **Can we Send a Text Message?** Yes ☐ No ☐	**Has the client consented and aware of this referral?** Yes ☐ No ☐ **Previous client of** ☐ WOTCH ☐ SEARCH ☐ CMHA When: Click here to enter a date.
Diagnosis: Yes ☐ No☐ Unsure☐	**Primary Diagnosis:**	**Current Supports:**	**Canadian Citizen:** Yes ☐ No ☐ **What is your mother tongue?** English ☐ French ☐ Other: **If your mother tongue is neither English nor French, in what official language are you most comfortable?** English ☐ French ☐	**Current Employment:** Yes ☐ No ☐ **Source of Income:**

Requesting Supports in following location:

☐ Strathroy Fax 519 245 0121 ☐ London Fax 519 668 3641 Queens Ave / Fax 519 438 1167 Huron Street ☐ Exeter Fax 519 235 3180 ☐ Goderich Fax 519 440 0776

Reason for Referral (what programs are you looking to connect to, what are client goals):

Current Housing Type	**Risk Factors**	**Comments:** (Please describe presenting concerns and provide any additional supporting documents, if applicable)
☐ Market Rent/Own	☐ Substance Abuse	
☐ Subsidized Rent	☐ Self Harm	
☐ Homeless	☐ Legal Involvement/Police Contact	
	☐ Other: Please explain ____________________	

INTAKE FORM

FOR INTAKE USE ONLY: MUST BE CONTACTED WITHIN 72 HOURS		
IF CLIENT IS NOT REACHED AFTER 2 contacts this intake will remain pending for 1 month		
Initial Contact Date: Click here to enter a date.	**Message Left**: ☐ Y	Worker:
2nd Contact Date: Click here to enter a date.	**Message Left**: ☐ Y	Worker:
Comments:	**Appointment Booked**: ☐ Y ☐ N	Date: Click here to enter a date. **Time**:
Completed by:	**Entered into CRMS/Roxy**: ☐ Yes ☐ No	
Red Flagged: ☐ Yes ☐ No	**Referral(s) made to**:	