

Central West LHIN Registration Form Mental Health and Addictions Services



Association canadienne
pour la santé mentale
Peel Dufferin
La santé mentale pour tous



Inquiries: Central Intake (905) 451-2123

Website: cmhapeeldufferin.ca

Acceptance of registration requires legible answers for all fields on the two pages, including indicating the choice not to answer.

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|--|--|-----|--|--|-------------|--|--|----|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| REGISTRANT'S INFORMATION | | | | | | | | | | Health Card #: | | | | | | | | | | | | | | |
| Last Name: | | | | | First Name: | | | | | Gender: | | | | | <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Male <input type="checkbox"/> Other: | | | | | <input type="checkbox"/> Trans <input type="checkbox"/> Do not Know <input type="checkbox"/> Prefer not to answer | | | | |
| Birth Date: | | Day | | | Month | | | Yr | | | | | | | | | | | | | | | | |
| Street Address: | | | | | | | | | | Postal Code: | | | | | | | | | | | | | | |
| City/Town, Prov.: | | | | | | | | | | Postal Code: | | | | | | | | | | | | | | |
| Email: | | | | | | | | | | Internet access? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | | | |
| Home: | | | | | | | | | | Cell: | | | | | <input type="checkbox"/> Yes, you may text | | | | | | | | | |
| What details can be left in a message? <i>(after the second failed attempt to contact you, your alternate contact will be phoned/emailed)</i> | | | | | | | | | | <input type="checkbox"/> Caller's Name <input type="checkbox"/> Reason for call | | | | | <input type="checkbox"/> Agency Name <input type="checkbox"/> Follow up Required | | | | | <input type="checkbox"/> Phone number <input type="checkbox"/> Appointment Info | | | | |
| Barrier to Communication: | | | | | | | | | | <input type="checkbox"/> Limited/no English <input type="checkbox"/> Cognitive <input type="checkbox"/> Hearing <input type="checkbox"/> Other: | | | | | <input type="checkbox"/> Sight <input type="checkbox"/> Other: | | | | | | | | | |
| If not most comfortable speaking in English, is an interpreter needed? | | | | | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | <input type="checkbox"/> Do not know | | | | | | | | | |
| Is this referral from an Emergency Department Visit for Addictions or Mental Health? | | | | | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify the hospital: | | | | | | | | | | | | | | |
| Is this referral from a Mental Health Inpatient unit? | | | | | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes, specify hospital: | | | | | | | | | | | | | | |
| Alternate Contact: | | | | | | | | | | Relationship: | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | Cell: | | | | | Email: | | | | | | | | | |

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|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--------------------------------|--|--|--|--|---|--|--|--|--|
| Reason for Referral: - concerns - diagnosis - situation - symptoms - risk to self/others | | | | | | | | | | | | | | | | | | | | | | | | |
| Medications (list or attach all current medications): | | | | | | | | | | | | | | | | | | | | | | | | |
| Supportive Housing requested? | | | | | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | Vocational Supports requested? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | |
| Referral Source Name: | | | | | | | | | | Billing #: | | | | | | | | | | | | | | |
| Professional Designation: | | | | | | | | | | Email: | | | | | | | | | | | | | | |
| Agency Name and Office Mailing Address: <i>(affix sticker or stamp)</i> | | | | | | | | | | Phone: | | | | | | | | | | | | | | |
| | | | | | | | | | | Fax: | | | | | | | | | | | | | | |

Before faxing clinical information, please ensure fax number (905-456-7492) is automatically programmed into your equipment.

This facsimile (fax) transmission is confidential, may contain legally privileged information and is intended for the review by only the individual or party to whom it is addressed, and for no one else. If it is received by someone other than the intended recipient, any dissemination, distribution or copy of this fax transmission is strictly prohibited. Please notify us immediately by phone and return the fax transmission to us by mail. We are compliant with current privacy legislation. We collect personal information for clinical service coordination assessment and treatment, research, and legal and regulatory purposes.

February 2017

We Ask Because We Care

Mental Health and Addictions providers in Brampton, Bramalea, Bolton/Caledon, Dufferin County, North Etobicoke, Malton, and west Woodbridge (the Central West LHIN) are collecting social information from individuals seeking service to find out who we serve and what are the unique needs amongst these individuals. We will also use this information to understand people's experiences and outcomes.

1. *Do I have to answer all the questions?* No. The questions are voluntary and you can choose 'prefer not to answer' to any or all questions. This will not affect your care.

2. *Who will see this information?* This information will be visible only to your health-care team and protected like all your other health information. If used in research, this information will be combined with data from all other individuals and no one will be able to identify any of the individuals seeking service.

What language would you feel most comfortable speaking in with your health care provider? Choose ONE.

| | | | | |
|--|------------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Amharic | <input type="checkbox"/> English | <input type="checkbox"/> Korean | <input type="checkbox"/> Somali | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Farsi | <input type="checkbox"/> Nepali | <input type="checkbox"/> Spanish | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> ASL | <input type="checkbox"/> French | <input type="checkbox"/> Polish | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Greek | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Tamil | |
| <input type="checkbox"/> Chinese (Cantonese) | <input type="checkbox"/> Hindi | <input type="checkbox"/> Punjabi | <input type="checkbox"/> Tigrinya | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Chinese (Mandarin) | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Russian | <input type="checkbox"/> Turkish | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Czech | <input type="checkbox"/> Italian | <input type="checkbox"/> Serbian | <input type="checkbox"/> Twi | |
| <input type="checkbox"/> Dari | <input type="checkbox"/> Karen | <input type="checkbox"/> Slovak | <input type="checkbox"/> Ukrainian | |

Were you born in Canada? Yes No Do not know Prefer not to answer

If not born in Canada, what year did you arrive? _____ Please check if the year provided is a guess/estimate

Which of the following best describes your racial or ethnic group? Choose ONE.

| | |
|--|---|
| <input type="checkbox"/> Asian - East (e.g. Chinese, Japanese, Korean) | <input type="checkbox"/> Latin American (e.g. Argentinean, Chilean, Salvadoran) |
| <input type="checkbox"/> Asian - South (e.g. Indian, Pakistani, Sri Lankan) | <input type="checkbox"/> Metis |
| <input type="checkbox"/> Asian - South East (e.g. Malaysian, Filipino, Vietnamese) | <input type="checkbox"/> Middle Eastern (e.g. Egyptian, Iranian, Lebanese) |
| <input type="checkbox"/> Black - African (e.g. Ghanaian, Kenyan, Somali) | <input type="checkbox"/> White - European (e.g. English, Italian, Portuguese, Russian) |
| <input type="checkbox"/> Black - Caribbean (e.g. Barbadian, Jamaican) | <input type="checkbox"/> White - North American (e.g. Canadian, American) |
| <input type="checkbox"/> Black - North American (e.g. Canadian, American) | <input type="checkbox"/> Mixed heritage (e.g. Black - African & White - North American) |
| <input type="checkbox"/> First Nations | <input type="checkbox"/> Please specify: _____ |
| <input type="checkbox"/> Indian - Caribbean (e.g. Guyanese with origins in India) | <input type="checkbox"/> Other(s): Please specify: _____ |
| <input type="checkbox"/> Indigenous/Aboriginal - not included elsewhere | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Inuit | <input type="checkbox"/> Prefer not to answer |

What is your sexual orientation? Choose ONE.

| | | | |
|---|--|---|----------------------------------|
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Gay | <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Lesbian |
| <input type="checkbox"/> Queer (a term used by people who do not follow common sexual orientations) | <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer | |
| <input type="checkbox"/> Two-Spirit (a term used by Aboriginal people) | <input type="checkbox"/> Other (Please specify): _____ | | |

What was your total family income before taxes last year? Choose ONE.

| | | | |
|--|--|--|--|
| <input type="checkbox"/> \$0 - \$14,999 | <input type="checkbox"/> \$20,000 – \$24,999 | <input type="checkbox"/> \$30,000 – \$34,999 | <input type="checkbox"/> \$40,000 – \$59,999 |
| <input type="checkbox"/> \$15,000 – \$19,999 | <input type="checkbox"/> \$25,000 – \$29,999 | <input type="checkbox"/> \$35,000 – \$39,999 | <input type="checkbox"/> \$60,000 or more |

How many people does this income support?

| | |
|--------------------------------------|---|
| <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer |
|--------------------------------------|---|