ST. LEONARD'S COMMUNITY SERVICES
ADDICTIONS AND MENTAL HEALTH
INTAKE REFERRAL FORM

Client Name: ____

Date of Referral: _____________________ Date of Birth: _____________________________
(dd/mm/yyyy) (dd/mm/yyyy)

Address: ____

Telephone: ____

Can a confidential message be left on voice mail? Yes No
Can a confidential message be left with others? Yes No

REFERRAL SOURCE:

Name/Title: ____________________________Agency: ____________________________

Telephone/Extension: __________________________ Fax: __________________________

Confirm that the individual aware that a referral has been made? Yes
Is the individual currently in hospital? Yes No
Hospital Floor/Room Number: ____

Estimated Discharge Date: ____

Presenting Issues: Drug Use ◯ Gambling ◯
Alcohol Use ◯ Concurrent Disorder ◯

Comments:
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***Please fax this referral form to 519-754-0264 Attn: Nicole Brown, Addictions and Mental Health Administrative Support. We will then connect with the patient or referral source.**