nova scotia health authority

Nova Scotia Health Authority

Community Mental Health

Referral Form

Patient name (full): _____

Address: _____

_____ Postal code: _____

Phone: (H) _____

(W) _____

(C) _____

Date of Birth: _____ Gender: _____

Health Card #: _____ Exp. _____

PLEASE FAX THIS COMPLETED FORM TO THE APPROPRIATE SERVICE

*** Re-check the fax number immediately below before sending to ensure the privacy of patients**

ASK YOUR PATIENT TO CALL THE APPROPRIATE LOCATION TO BOOK AN APPOINTMENT

☐ Bayers (Halifax)	☐ Bedford / Sackville	☐ Cole Harbour	☐ Dartmouth	☐ West Hants
Phone: 454-1400 Fax: 473-2506* *Risk of mis-dial	Phone: 865-3663 Fax: 865-2072* *Risk of mis-dial	Phone: 434-3263 Fax: 434-0181* *Risk of mis-dial	Phone: 466-1830 Fax: 466-1851* *Risk of mis-dial	Phone: 792-2042 Fax: 798-0709* *Risk of mis-dial

Family Physician Name: _____ **Fax #:** _____

Presenting Concerns: (We do not accept referrals for custody/access, legal or insurance purposes).

Please include level of distress symptoms and impact on their day to day life:

_____

_____

_____

_____

_____

What questions/issue(s) would you like addressed at this time? _____

_____

Medications: (Please include start date, dosage and response)

_____

_____

_____

Current and Past Mental Health Treatments/Services and Community Supports: (attach reports if available)

_____

_____

Working diagnosis: _____

We are not an Emergency Service. Patient in crisis should contact Mobile Crisis at 1-888-429-8167

Referred by: (please print) _____ **Date:** _____

Agency / Practice: _____ **Phone:** _____

PLEASE ENSURE THIS FORM IS COMPLETED IN FULL