ENYONKWA'NIKONHRIYOHAKE'
WE ALL HAVE A GOODMIND

ENYONKWA'NIKONHRIYOHAKE' PROGRAM

50 Meadow Drive, Tyendinaga Mohawk Territory, Ontario K0K 1X0
Phone (613) 967-0122 **Fax (613) 962 4210**

REFERRAL FORM

(Please email completed form or submit in person to goodmindsadmin@mbq-tmt.org)

Section A – General Information

Indigenous Status: ☐ Status ☐ Status Eligible ☐ Non-Status/Self-Identified

(If status or status eligible) Band Affiliation:

Client Name:

Client DOB:

Client Age:

Client's preferred pronouns:

Is the client over the age of 16 and/or able to make their own legal decisions? ☐ Y ☐ N

(If the answer is no)

Legal Caregiver/Decision Maker:

Name:

Contact number:

Has consent been given by the legal caregiver/decision maker for this referral to be made?

☐ Y ☐ N

(***If the above answer is no**, advise that before a referral can be completed, verbal or written consent must be received by the legal caregiver/decision maker.)*

Does the client currently have stable housing? ☐ Y ☐ N

(If Yes) Client Address:

(If No) Client's Current living situation:

Client Contact Number:

Can we leave a voicemail at this number? ☐ Y ☐ N

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Section B – Third Party Referral – (Skip if client is self-referring) Referring Program/Agency:

Contact Name:

Contact Number:

Signed information sharing consent attached:

☐ Y ☐ N

Reason for Referral: (Brief detailed narrative)

*Ex: "Client X has identified struggling with feelings of **anxiety**" /Ex: "Client X has **legal concerns** that involve **substance use**" /Ex: "Client X would like to explore **options for residential treatment services**." Ex: Client X has difficulty **managing powerful emotions**." /Ex: Client X is **experiencing problems at school."***

How would you categorize the client's level of risk to self or to others?

☐ Low

☐ Medium

☐ High

Low: Client has safe and stable housing. Client does not identify any substance use or major mental health concerns. Client typically attends appointments and can express themselves appropriately.

Medium: Client identifies substance use, mental health, legal, child protection or domestic violence concerns. Client has an upcoming discharge from hospital or release from incarceration. Client has a health dependent Rx but no regular prescriber.

High: Client presents with any of the following: No fixed address, opioid use without current Opioid Agonist Therapy, recent incarceration paired with a history of opioid use, client has thoughts of suicide, has /is displaying major mental health symptoms, displays aggressive behaviour and/or difficulties communicating emotions.