Canadian Mental Health Association South Cariboo

Request for Services

Personal information entered on this form will be retained by The Canadian Mental Health Association South Cariboo Branch, in accordance with its privacy and records policies and provincial/federal privacy protection legislation.

Client Details

CLIENT 1

Full name:	Pronouns:	Gender:
Does client identify as Indigenous? ☐YES ☐NO If YES: ☐First Nations ☐Metis ☐Inuit		Date of birth: YYYY-MM-DD
Mailing address:	Emergency contact number:	
Physical address:	Emergency contact name and relation:	
Phone number (authorized for us to contact you):	May we leave voice messages? ☐YES ☐NO	Email address:

CLIENT 2 (IF APPLICABLE)

Full name:	Pronouns:	Gender:
Does client identify as Indigenous? ☐YES ☐NO If YES: ☐First Nations ☐Metis ☐Inuit		Date of birth: YYYY-MM-DD
Mailing address:	Emergency contact number:	
Physical address:	Emergency contact name and relation:	
Phone number (authorized for us to contact you):	May we leave voice messages? ☐YES ☐NO	Email address:

CHILD DETAILS (IF APPLICABLE)

CHILD 1	CHILD 2	CHILD 3	CHILD 4
Name:	Name:	Name:	Name:
Date of birth: YYYY-MM-DD	Date of birth: YYYY-MM-DD	Date of birth: YYYY-MM-DD	Date of birth: YYYY-MM-DD
Does child identify as indigenous? ☐ YES ☐NO If YES: ☐ First Nations ☐Metis ☐Inuit	Does child identify as indigenous? ☐ YES ☐NO If YES: ☐ First Nations ☐Metis ☐Inuit	Does child identify as indigenous? ☐ YES ☐NO If YES: ☐ First Nations ☐Metis ☐Inuit	Does child identify as indigenous? ☐ YES ☐NO If YES: ☐ First Nations ☐Metis ☐Inuit
Gender:	Gender:	Gender:	Gender:
Who does child reside with?	Who does child reside with?	Who does child reside with?	Who does child reside with?
Other important information:	Other important information:	Other important information:	Other important information:

ADDITIONAL CLIENT INFORMATION

Does the client have a parent, guardian or other relative with contact information? Is there child custody, protection, or child-in-care information we should be aware of? Are there accessibility needs? Please enter any integral information regarding referred clients here:

If there is a pertinent court order, is a copy included: ☐YES ☐NO

If applicable, what relevant services/programs is the client already participating in, external to CMHA SC?

If applicable, has the client completed any relevant assessments? Are the assessments being submitted with this referral? If not, why?

Requested Service:

- Counselling Services:
  - □ Individual Counselling
  - □ Family Therapy
  - □ Relationship Counselling
  - □ Other: _____
- ☐Other (please define): _____

Description of situation and/or services requested:

Goal(s) for client(s):

Referring Agency (if Applicable)

Agency name:	Referral date: YYYY-MM-DD
Worker name:	Contact phone number:

Service Agreement

I have read this form and had the opportunity to ask questions, and I agree to this request for services. I understand a CMHA South Cariboo Employee will contact me within 10 business days for intake purposes. I understand I must submit government-issued photo identification as part of requesting services from CMHA South Cariboo.

Client name:	Client signature:	Signing date: YYYY-MM-DD
2nd Client name (if applicable):	2nd Client signature (if applicable):	Signing date: YYYY-MM-DD
Referring worker's name:	Referring worker's signature:	Signing date: YYYY-MM-DD

CMHA SC INTERNAL USE

Supervisor Name:	Referred to:	Referral Date: YYYY-MM-DD	Past Services: ☐YES ☐NO
Notes:			

Please submit this form in person at our office or by mail. We do not recommend you email this form to us: any included information is not secure in transit and may be vulnerable to external sources. If you do choose to email this form, you do so at your own risk.

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