ADDICTIONS AND MENTAL HEALTH SERVICES – KFLA
SELF-REFERRAL

☐ **Self-Referral** ☐ **Return to Service** ☐ **Referral for a Family Member/Friend**

SERVICES

What help is needed?
(Check ALL that apply)

- ☐ Mental Health
- ☐ Addiction
- ☐ Housing
- ☐ Employment
- ☐ Gambling/Gaming
- ☐ Other (specify

_____

REFERRAL SOURCE IF OTHER THAN SELF

Name

Relationship:

Address:

Phone:

PLEASE NOTE:

Is the individual being referred aware of this referral? ◯ Yes ◯ No

CONTACT INFORMATION

First Name:

Last Name:

Last Name at Birth:

Gender:

Date of Birth:

Address:

Do you have a Mental Health diagnosis?

◯ No ◯ Yes

Preferred Language: **Interpreter needed?**

BEST way to contact:

☐ **Phone** ☐ **Text** ☐ **Email** ☐ **Mail**

Phone number:

Can a detailed message be left at this number?

Email:

Alternate contact person:

Name:

Relationship:

Phone:

Can a detailed message be left at this number?

COMMENTS / HOW CAN WE HELP YOU?:

SIGNATURE:

REFERRAL TAKEN BY:

Date: ____ / ____ / ____
dd mm yyyy