North of Superior Counselling Programs (NOSP) – Referral Form

PLEASE NOTE THAT INCOMPLETE REFERRALS WILL BE RETURNED

◯ The individual for whom this referral applies, has consented to have this referral submitted to NOSP.

Referent Information:	
Name: ______________________	◯ Self ◯ Family ◯ Primary Care Practitioner ◯ Third Party ◯ Agency: ______________________
Referral Date (yyyy/mm/dd):	Referent Phone Number:

Referred Individual:

Legal last name	Legal first name		Middle Name
Preferred name (goes by)	Date of birth (yyyy/mm/dd)		
Street address	PO Box	Town/Township	Postal Code

Indicate contact information and check off preferred method(s):			**Can message be left?**	
School name:	◯ at school only (for youth self-referral)		Y	N
Cell phone:	◯ call	◯ text	Y	N
Work phone:	◯ call	◯ text	Y	N
Home phone:	◯		Y	N
Email:	◯		Y	N
Can we send mail correspondence to your home address? Y N				

Preferred language: ◯ English ◯ French ◯ Other: ______________________

Accommodation needs: ◯ Reading ◯ Writing ◯ Mobility ◯ Other:

Name of school/daycare (if applicable): ______________________ Grade: ________

Legal guardian if child under 12*: ______________________ Contact number: ______________________

Legal guardian if child under 12*: ______________________ Contact number: ______________________

**may be required to provide verification of legal guardianship at intake*

Primary Care Provider (Family Doctor or Nurse Practitioner): ______________________ ◯ none

Phone & Extension: ______________________ Fax: ______________________

Are child protection services involved? Y N If yes, name of agency: ______________________

Crown wardship or kinship agreement? Y N Comments: ______________________

Has individual received services at NOSP previously? Y N

If yes, what name did individual previously go by? ______________________

Presenting Issues:

◯ Anger issues ◯ Anxiety ◯ Caregiver burden/stress ◯ Coping challenges ◯ Energy level changes ◯ Feelings of hopelessness/ worthlessness ◯ Financial insecurity ◯ Food insecurity ◯ Gender orientation ◯ Grief/loss	◯ Hallucinations ◯ Homeless/risk of homelessness ◯ Intrusive repetitive thoughts ◯ Loneliness/isolation ◯ Loss of interest ◯ Memory difficulties ◯ Paranoid thoughts/ delusions	◯ Parenting challenges ◯ Physical health concerns ◯ Pregnancy – current ◯ Pregnancy – recent loss ◯ Problem gambling ◯ Racing thoughts ◯ Relationship problems ◯ Risk of family breakdown ◯ Sadness/depressed mood ◯ School/work difficulties	◯ Self harm behavior ◯ Separation/divorce ◯ Sexuality ◯ Sleep pattern changes ◯ Stress levels heightened ◯ Substance misuse ◯ Suicidal ideation – chronic ◯ Trauma ◯ Worries excessively/panics ◯ Other:

Reason for referral:

Referral comments (please include any formal diagnosis and relevant health issues); ◯ additional information attached:

Risk factors/safety concerns:

Current self harm behavior(s)	Y	N	Past history of self harm behavior(s)	Y	N
Current suicidal ideation (not at imminent risk)	Y	N	Past history of suicidal ideation and/or action	Y	N
Current risk of harm to others	Y	N	Past history of causing harm to others	Y	N
Interpersonal violence	Y	N	Other:	Y	N

Service(s) requested (please check)

CHILDREN'S SERVICES (0-17 years); PARENT/GUARDIAN SUPPORT

◯ Mental health counselling ◯ Substance use assessment and counselling ◯ Developmental services access/assessment ◯ Rural psychology/psychiatry	◯ Case management/service coordination ◯ Parenting support and targeted intervention ◯ Targeted prevention, education and skills support

ADULT SERVICES (18 years +)

◯ Mental health counselling ◯ Substance use assessment and counselling ◯ Problem gambling assessment and counselling ◯ Mental health case management ◯ Housing case management ◯ Housing case management with rental supplement ◯ Support and visiting for seniors, adults with physical disabilities and caregivers – Enrichment and Social Engagement (EASE)	If individual referred for **housing supports**, risk factor(s): ◯ homeless ◯ couch surfing ◯ unsafe housing ◯ risk of losing housing If individual referred for rental supplement and housing supports, income: ◯ Ontario Works ◯ ODSP ◯ No income ◯ Other: If individual referred for **EASE** has Power of Attorney for Personal Care**: POA legal last name — POA legal first name Preferred contact information for POA ***may be required to provide verification of POA at intake*
◯ Psychiatry consultation (referrals can only be made by a Primary Care Practitioner)	____________________________ Signature of Primary Care Provider (required) ◯ Current medication list attached

Fax completed referral to:	**Greenstone: 807-854-0006** **Nipigon/Armstrong: 807-887-2764**	**Marathon: 807-229-3040** **Schreiber/Terrace Bay/Manitouwadge: 807-824-1121**

OR COMPLETE AND SUBMIT ON-LINE AT WWW.NOSP.ON.CA