



Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Work, Stress and Health Program Assessment Referral Form

Client Information:

Name:	
Address:	
Telephone No.:	
Email:	

Availability for Assessment:

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Referral Source:

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Coordinator / Contact Information:

Billing Information:

Company:		Company:	
Contact Name:		Contact Name:	
Address:		Address:	
Tel. No.:		Tel. No.:	
Email:		<i>*Cancellation policy: We need 2 business days notice or a 50% cancellation fee will be applied. **Extra charges will be billed as Other Disbursements, i.e. courier and transportation costs, etc.</i>	

Referral Questions: (please mark with x)

- | | |
|----------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Contributing factors |
| <input type="checkbox"/> Treatment recommendations | <input type="checkbox"/> Prognosis |
| <input type="checkbox"/> Ability to work | <input type="checkbox"/> Other |

Presenting Problems / Description of Issues:

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- Is substance use an issue? Yes No
 Is risk for violence an issue? Yes No

For what purpose will the report be used?

- | | |
|-------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Capacity to work | <input type="checkbox"/> Disciplinary issues |
| <input type="checkbox"/> Litigation | <input type="checkbox"/> Insurance benefits |
| <input type="checkbox"/> Other | |

Please forward cover letter, all collateral information and consents to:

Work, Stress and Health Program
 455 Spadina Avenue, Suite 200
 Toronto, Ontario M5S 2G8
 Telephone: (416) 260-4147
 Fax: (416) 971-7172

For Office Use Only

Date Referral Received

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